STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345284	A. BUILDING _____ B. WING _____	C 07/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE OAKS	901 BETHESDA ROAD WINSTON SALEM, NC 27103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Recertification survey, complaint investigation and a focused infection control survey was conducted from 7/19/2021 through 7/23/2021. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # Y50K11.	E 000		
F 000	INITIAL COMMENTS A recertification surevey, complaint investigation and focused infection control survey were conducted onsite from 7/19/2021 through 7/22/2021 and additional information was obtained on 7/23/2021. The exit date was 7/23/2021. Event ID# Y50K11 20 of the 51 complaint allegations were substantiated resulting in deficiencies.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis,	F 550		8/20/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 08/16/2021

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F 550	Continued From page 1 severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews, and record review the facility failed to treat a resident in a dignified manner by not keeping his living environment clean for 1 of 9 residents (Resident #68) reviewed for dignity. The Resident expressed feeling unclean and embarrassed by the condition of his room. The findings included: Resident #68 was admitted to the facility on 4/23/2020. The most recent quarterly Minimum Data Set (MDS), dated 5/27/2021, revealed the resident	F 550	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F550 1. Corrective action for resident(s) affected by the alleged deficient practice:	

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F 550	Continued From page 2 was cognitively intact. An observation of the 500-hall common area occurred on 7/19/2021 at 12:18 PM and revealed a strong urine odor that lingered into the common sitting area. An observation of Resident #68's room occurred on 7/19/2021 at 12:20 PM and revealed a strong urine odor. The floors were sticky on both sides of the room. In the Resident's bathroom, there was a yellow coating around the toilet and the floor was sticky. Dark stained grout on a tile floor was noted next to the toilet and the baseboard of tile. An interview was conducted on 7/20/2021 at 9:36 AM with Nursing Assistant (NA) #02 and she revealed she had been employed with the facility for several weeks and that the urine odor in Resident #68's room had been present since she began employment. She revealed this was her primary assignment. She stated that housekeeping was made aware of the strong smell and sticky floors. An interview was conducted with Resident #68 on 7/20/2021 at 9:50 AM and revealed he (Resident #68) required assistance with going to the bathroom and used a brief. He said the urine smell was strong when he first moved into the room. He added that he reported the issue at the front office to the administrator, and nothing was done. He stated he had observed staff and visitors wrinkle their noses when walking past the room in the hall or when they enter. He revealed that the sticky floors and the urine odor make him feel unclean and embarrassed. He revealed his family did not live in the area and because of travel restrictions had not been able to visit during	F 550	For resident #68: The Administrator directed the Housekeeping staff on 7.23.21 to change mattress and seat cushion for resident, strip and wax the floor, and treat the floor with an odor eliminating product. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. Beginning on 7/23/2021 the Director of Nursing and Environmental Services Manager audited 100% of all resident rooms to identify any residents who had odors in their room that would identify any residents where the odor would prevent them from having a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. Results: 3 out of 98 residents were identified with odors in their room that interfered with their rights to a dignified existence; rooms cleaned, treated with odor eliminating product. New flooring ordered for 2 of the 3 rooms. 3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: The policy for Residents Rights was reviewed and applied to this situation. There was no change required in the policy. On 08.12.2021, the Administrator began reeducating all full time, part time, and PRN Housekeepers on the following:	

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F 550	Continued From page 3 the COVID 19 pandemic but if they decided to visit now, he would be embarrassed for them to enter his room. An observation of Resident #68's room occurred on 7/20/2021 at 9:52 AM and revealed the floor in the bathroom continued to have dark stains in the grout between the tile surrounding the toilet and going ¾ of the way up the grout on the tiled baseboard. The smell was a strong ammonia urine smell and lingered into the hall 10 feet past the room. The Resident was observed lying in the bed with a dark brown smeared dried substance on the right-hand side of his pillowcase the size of the palm of a hand. The Resident denied knowing what the substance was. An interview was conducted with the Housekeeping manager in Resident #68's room, on 7/21/2021 at 9:08 AM and she revealed she was aware of the strong urine odor and sticky floor in the room. She revealed that this was one of two rooms that had a resident with issues of urinating in various locations and missing the toilet when urinating. She stated that the tile floor absorbs the smell and the urine and then it is tracked into the room with the wax floors, causing the wax to become sticky. She added that for this reason, the floors in the room are buffed twice a week. She added that the wax is not removed with buffing. She revealed the behaviors of urinating in various locations was not Resident # 68. She stated it was difficult to remove excess urine odors from grout and she was not sure what else to do, other than replacing the floor, to improve the smell and environment in the room. She stated she had received concerns from staff about the urine in the bathroom and the smell of the room.	F 550	• Residents Rights/Exercise of Resident Rights • Housekeeping Policy This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. The facility specific in-service will be provided to all full time, part time, and PRN Housekeepers. Any staff who does not receive scheduled in-service training will not be allowed to work until training has been completed by 08.20.2021. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Administrator or designee will monitor compliance utilizing the F550 Quality Assurance Tool weekly x 4 weeks then monthly x 3 months. The tool will monitor reports of any facility odors that would prevent the resident from having a dignified existence. Reports will be presented to the weekly Quality Assurance (QA) committee by the Administrator to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting, indefinitely or until no	

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F 550	Continued From page 4 An observation was conducted of Resident #68's room on 7/21/2021 at 9:10 AM and the room and hallway outside of the room smelled of a strong, lingering ammonia urine odor. The floors continued to be sticky and the tile in the bathroom continued to have dark stains with urine around the edge of the toilet. An interview was conducted with the Administrator on 7/21/2021 at 9:28 AM and she revealed that she was aware of the issue with Resident #68's room, regarding the urine odors. She stated she was not aware he was embarrassed. She added that the Resident spends most of his day outside of his room and at the front of the building. She stated it was her expectation that the facility does not have a situation where a resident would be embarrassed by the housekeeping or physical environment in their room or to receive a family visitor in the privacy of their room.	F 550	longer deemed necessary for compliance with room odor. The weekly QA Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager.	
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);	F 580		8/20/21

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F 580	Continued From page 5 (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on staff and resident representative interviews, and medical record review, the facility failed to notify the resident representative of a	F 580	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the	

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F 580	Continued From page 6	F 580		

new skin wound for 2 of 2 residents (Resident #214 and Resident #317) reviewed for notification of change in condition.

Findings included:

1.Resident #214 was admitted to the facility on 9/11/20 with diagnoses left femur/hip fracture, type 2 diabetes, end stage renal disease.

Most recent Minimum Data Set (MDS) dated 9/18/20 showed she was minimally cognitive impaired, frequently incontinent of bladder and bowel, and she required extensive 2 person assistance for bed mobility and transfers. There were no pressure ulcers.

Resident #214's medical record revealed her responsible party and the only family representative on file.

Further medical record review revealed a skin assessment completed 9/11/20 upon admission with no skin wounds noted on Resident #214's buttocks.

A treatment plan for a right buttock wound dated for 10/12/20 was located for Resident #214.

Resident #214 was discharged from the facility on 12/18/20.

An interview with Resident's #214's responsible party (RP) was conducted 7/21/21 at 11:10 AM. The RP stated that Resident #214 did not have any skin issues prior to entry to the facility. He stated that Resident #214 told him that she thought she had a sore on her bottom one day in October. He was unsure how long it has been

alleged deficiencies.
To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated.
F580
1. Corrective action for resident(s) affected by the alleged deficient practice:

Resident #317 was discharged from the facility on 02.03.2020 and therefore corrective action could not be completed with legal representative.

Resident #214 was discharged from the facility on 12.18.2020 and therefore corrective action could not be completed with legal representative.

2. Corrective action for residents with the potential to be affected by the alleged deficient practice.

On 07.27.2021 the Director of Nurses/Treatment Nurse reviewed all new wound treatment orders for the last 14 days from 07.23.2021 to ensure that the legal representative/resident had been informed of any newly identified wounds.
Results: All residents and/or legal representatives were/were not notified of all changes. Any residents and/or legal representatives who were identified as not being notified of changes were immediately notified of the changes.

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F 580	Continued From page 7	F 580		

there or if they were treating it. He denies ever being notified by the facility that his mother had a wound on her buttocks. The RP stated the wound was confirmed to him when Resident #214 showed it to him.

An interview with the Director of Nursing on 7/22/21 at 12:22 PM revealed that the proper procedure for staff to follow when there is a change in condition of the resident is for the nurse who documents it in the resident's record, to also notify the responsible party. The facility was unable to locate any documentation that Resident's #214's responsible party was notified about her wound.

2. Resident #317 was admitted to the facility on 8/12/19 with diagnoses hypertension, severe protein malnutrition, type 2 diabetes mellitus, and cardiomyopathy.

Resident #317's admitting Minimum Data Set (MDS) dated for 11/28/19 showed no pressure ulcers or skin breakdown under section M. It also revealed that he required one person assistance for bed mobility, transfers, and toileting.

A record review on 7/20/21 showed a nurse note dated 1/21/20 at 10:49 PM written by Nurse #5 stating that she observed an open area to upper intergluteal cleft. He was discharged on 2/3/20 to the hospital for a different concern.

A statement made by Resident #317's responsible party on 2/11/2020 indicated the family had no idea Resident #317 had a wound on his buttocks until he met him at the hospital on 2/3/20. She stated that no one from the facility called to let them know about this change in

3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice:

On 07.23.2021, the Director of Nursing (DON), Treatment Nurse, Administrator, and the Quality Assurance Clinical Nurse Consultant reviewed the policy on Responsible Party Notification of Resident Condition. There were no changes required to the policy. On 07.25.2021, the Director of Nurses/Staff Development Coordinator began reeducation of all full time, part time and as needed nurses and agency nurses on immediate notification of the resident/resident representative of any significant change in the resident□s physical, mental, or psychosocial status (that is a deterioration in health, mental or psychosocial status in either life-threatening conditions or clinical complications).

This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. Any staff who does not receive scheduled in-service training will not be allowed to work until training has been completed by 08.20.2021.

The facility will review this information in their clinical meeting and discuss any issues at least weekly for the next 3 months unless the Quality Assurance

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F 580	Continued From page 8 condition. The facility was unable to provide any documentation that the responsible party was notified of Resident #317's change in condition. An interview with the Director of Nursing on 7/22/21 at 12:22 PM revealed that the proper procedure for staff to follow when there is a change in condition of the resident is for the nurse who documents it in the resident's record, to also notify the responsible party. The facility was unable to locate any documentation that Resident's #317's responsible party was notified about his wound.	F 580	Committee feels this issue has been resolved sooner. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The DON or designee will monitor compliance utilizing the F580 Quality Assurance Tool weekly x 4 weeks then monthly x 3 months. The DON will monitor compliance to ensure that each resident or resident representative receives notification of any significant change in the resident□s physical, mental, or psychosocial status. Reports will be presented to the weekly Quality Assurance committee by the DON to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance (QA) Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Coordinator, Unit Support Nurses, Therapy Manager, Health Information Manager, and the Dietary Manager.	
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.	F 584		8/20/21

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F 584	Continued From page 9 The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews, and record review, the facility failed to maintain a clean and odor free living environment	F 584	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the	

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F 584	Continued From page 10 for 2 of 26 residents (Resident #15 and Resident #68), failed to maintain a nightstand in good repair for 1 of 26 residents (Resident #15), and failed to place a resident's personal laundry in drawers or the closet for 1 of 26 residents (Resident #107) reviewed for environment. The Findings included: 1A. Resident #68 was admitted to the facility on 4/23/2020. The most recent quarterly Minimum Data Set (MDS), dated 5/27/2021, coded the Resident was cognitively intact and able to communicate his needs. An observation of the 500-hall common area occurred on 7/19/2021 at 12:18 PM and revealed a strong urine odor that lingered into the common sitting area. An observation of Resident #68's room, room 509, occurred on 7/19/2021 at 12:20 PM and revealed a strong urine odor with floors that were sticky in the room. In the Resident's bathroom, there was a yellow coating around the toilet and the floor was sticky. Dark stained grout on a tile floor was noted next to the toilet and the baseboard tile. An interview was conducted on 7/20/2021 at 9:36 AM with Nursing Assistant (NA) #02 and she revealed she had been employed with the facility for several weeks and that the urine odor in Resident #68's room had been present since she began employment. She revealed this was her primary assignment. She stated that housekeeping was made aware of the strong smell and sticky floors.	F 584	alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F584 1. Corrective action for resident(s) affected by the alleged deficient practice: On 07.25.2021, the room for resident #15 was cleaned by the housekeeping staff to include sweeping and mopping of floor, nightstand, overbed lighting and windowsills. The housekeeping staff also ensured that there was no odor in the room. The night stand for this resident was replaced on 07.26.2021. On 7.23.2021, the room for resident #68 was cleaned by the housekeeping staff to include sweeping and mopping of floor, nightstand, overbed lighting and windowsills. The housekeeping staff also ensured that there was no odor in the room. On 07.23.2021, the laundry and clothing for resident #107 was placed in the appropriate place (closet and drawers). 2. Corrective action for residents with the potential to be affected by the alleged deficient practice:	

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THE OAKS	901 BETHESDA ROAD WINSTON SALEM, NC 27103

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F 584	Continued From page 11 An interview was conducted with Resident #68 on 7/20/2021 at 9:50 AM and he revealed that to his knowledge the odor in his room and the urine came from his roommate. He stated he required assistance with going to the bathroom and used a brief. He said that he was placed with this roommate and the urine smell was strong when he first moved into the room. He added that he reported the issue, and nothing was done. He stated he had observed staff and visitors wrinkle their noses when walking past the room in the hall or when they enter. An observation of Resident #68's room occurred on 7/20/2021 at 9:52 AM and revealed the floor in the bathroom continued to have dark stains in the grout between the tile surrounding the toilet and going ¾ of the way up the baseboard tile grout. The smell was a strong ammonia urine smell and lingered into the hall. An interview was conducted with the Housekeeping manager in room 509, on 7/21/2021 at 9:08 AM and she revealed she was aware of the strong urine odor and sticky floor in the room. She revealed that this was one of two rooms with issues of urine odor. She stated that the tile floor absorbs the smell and the urine and then it is tracked into the room with the wax floors, causing the wax to become sticky. She added that for this reason, the floors in the room are buffed twice a week. She stated it was difficult to remove excess urine odors from grout and she was not sure what else to do, other than replacing the floor, to improve the smell and environment in the room. She stated she had received concerns from staff about the urine in the bathroom and the smell of the room.	F 584	100% audit of all rooms in the facility was completed by the Floor Technician/Housekeeper on 07.23.2021 to ensure that all rooms were cleaned according to policy. Results: 23 of 76 floors for stripping and waxing identified. Any rooms not cleaned properly were reported to Environmental Director and cleaned per policy. 100% audit of all rooms in the facility was completed by Director of Nursing and Environmental Services Director on 07.23.2021 to ensure that all rooms were free of odor. Results: 3 of 76 rooms identified. Any rooms that had an odor received interventions to reduce odors. 100% audit of all rooms in the facility was completed by the Environmental Services Director/Maintenance Director on 07.23.2021 to ensure that all night stands were in good repair. Results: 5 of 76 rooms needed replacement/repair. Any rooms that identified night stands in need of repair received the necessary repairs and replacements of night stands. 100% audits of all rooms in the facility was completed by Environmental Services Director on 07.23.2021 to ensure that all resident□s personal laundry was stored in drawers or closets. Results: 8 of 98 residents needed personal laundry placed in drawers/closet. Any rooms that identified personal laundry not stored in the proper place was immediately stored away properly per resident guidance/request.	

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F 584	Continued From page 12 An observation was conducted of Resident #68's room on 7/21/2021 at 9:10 AM and the room and hallway outside of the room smelled of a strong, lingering ammonia urine odor. The floors continued to be sticky and the tile in the bathroom continued to have dark stains with urine around the edge of the toilet. An interview was conducted with the Administrator on 7/21/2021 at 9:28 AM and she revealed that she was aware of the issue with Resident #68's room, regarding the urine odors. She added that the Resident spends most of his day outside of his room and at the front of the building. She stated it was her expectation that the facility does not have a situation where a resident would be embarrassed by the housekeeping or physical environment in their room and that they be provided a clean living environment to the best of the facilities abilities. 1B. Resident #15 was admitted to the facility on 6/20/17. The comprehensive Minimum Data Set assessment dated 4/3/21 indicated Resident #15 was cognitively intact. An observation of Resident #15's room on 7/19/21 at 11:56 AM revealed there were brown stains on the floor and the floor was sticky on the right side of Resident #15's bed. An interview was conducted with Resident #15 on 7/19/21 at 11:57 AM, during which he said he didn't know what caused the brown stains on the floor but that it had "been there awhile." Observations of Resident #15's room on 7/20/21 at 2:35 PM and 7/21/21 at 12:56 PM revealed	F 584	3. Measures/Systemic changes to prevent reoccurrence of alleged deficient practice: Education: All housekeepers will be re-educated by the Administrator starting on 08.12.2021 on cleaning rooms according to policy on regular intervals to include dust mop and damp mop resident room floors, empty trash receptacles, replenish toilet tissue, paper towels, soap, hand sanitizer, and odor control. Clean furnishings used by residents and visitors. Clean spot on walls. Complete cleaning of bathrooms. Complete cleaning of window blinds and window sills on regular intervals. Cubicle curtains on regular intervals or as needed. Sanitize beds on deep cleaning schedules. Additionally, all laundry staff were educated on storing resident□s personal laundry in the drawer or closet of the resident using the Resident Rights/Personal Laundry Policy/Housekeeping Policy. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. The facility specific in-service will be provided to all laundry and housekeeping staff. Any staff who does not receive scheduled in-service training will not be allowed to work until training has been completed by 08.20.2021. 4. Monitoring Procedure to ensure that	

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F 584	Continued From page 13 brown stains on the floor and the floor was sticky on the right side of Resident #15's bed. During an interview with Housekeeper #1 on 7/20/21 at 2:50 PM she reported she cleaned Resident #15's room daily and mopped the floor. She explained if the floor was still sticky after it had been mopped then the floor needed to be stripped and waxed again. An observation of Resident #15's room was completed with Housekeeper #1 on 7/20/21 at 2:57 PM. She verified the floor was sticky and said she was unsure what the brown stains on the floor were from but that it hadn't come out of the floor when she mopped the room earlier in the day. An observation of Resident #15's floor was completed with the Director of Environmental Services (DES) on 7/22/21 at 1:16 PM. She described the floor in Resident #15's room as having a "build up of wax and needed to be stripped and waxed." In an interview on 7/22/21 at 1:18 PM the DES explained housekeeping staff swept and mopped floors daily in residents' rooms. She shared there was one floor technician who stripped and waxed floors for the entire building and sometimes she had to pull him to other duties such as buffing floors. She added the floor technician worked 6 ½ hours per day, 5 days per week. The DES stated the floor technician focused on resident rooms that had sticky floors, bad odors or stains around the edge of the room. She had scheduled Resident #15's floor to be stripped and waxed the week of 7/21/21 but had assigned the floor tech to work on buffing floors and assisting with a delivery of supplies. An interview was completed with the	F 584	the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Administrator or designee will monitor compliance utilizing the F584 Quality Assurance Tool weekly x 4 weeks then monthly x 3 months. The tool will monitor reports of housekeeping issues and personal laundry issues. Reports will be presented to the weekly Quality Assurance (QA) committee by the Director of Nurses to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting, indefinitely or until no longer deemed necessary for compliance with the housekeeping and personal laundry issues. The weekly QA Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Coordinator, Therapy Manager, Health Information Manager, Environmental Services Manager, and the Dietary Manager.	

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Administrator on 7/22/21 at 3:55 PM. She shared the facility had staffing issues in the housekeeping department and needed more floor technicians. She said at times the floor technician was pulled to the laundry department or another area which prevented the floors from being stripped and waxed.

2. Resident #15 was admitted to the facility on 6/20/17. The comprehensive Minimum Data Set assessment dated 4/3/21 indicated Resident #15 was cognitively intact.

An observation of Resident #15's room on 7/19/21 at 11:56 AM revealed the vinyl on the front of the three drawer nightstand had partially peeled away from the nightstand.

During an interview with Resident #15 on 7/19/21 at 11:57 AM he said he had been in the room for over a year and the nightstand had been in the same condition since he resided in the room.

Observations of Resident #15's room on 7/20/21 at 2:35 PM and 7/21/21 at 12:56 PM revealed the vinyl on the front of the nightstand had partially peeled away from the nightstand.

On 7/22/21 at 1:05 PM an observation of Resident #15's nightstand was completed with the Maintenance Director. During an interview with the Maintenance Director on 7/22/21 at 1:11 PM, he said the vinyl on the nightstand had peeled away and advised the nightstand needed to be discarded and a new one placed in Resident #15's room. He reviewed the maintenance work orders and shared there were no work orders for Resident #15's room since January 2021. He added he hadn't typically

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checked rooms routinely for furnishings in disrepair and said the furnishings were kept in the housekeeping department and they were responsible for replacements when a piece of furniture was in disrepair.

An observation of Resident #15's nightstand was completed with the Director of Environmental Services (DES) on 7/22/21 at 1:16 PM. In an interview on 7/22/21 at 1:18 PM the DES explained housekeeping staff should have notified her that the nightstand was in disrepair. During the observation she said she was unaware of the condition of the nightstand and indicated it needed to be discarded and a new one brought into Resident #15's room.

An interview was completed with the Administrator on 7/22/21 at 3:55 PM. She stated the facility had not completed room audits routinely or looked for furniture in disrepair and shared she would be adding room audits on a scheduled basis for regular monitoring.

3. Resident #107 was admitted to the facility on 6/18/21 with diagnoses of Parkinson's disease and dementia.

The Admission Minimum Data Set (MDS) assessment dated 6/25/21 revealed Resident #107 had moderately impaired cognition and required extensive assistance to total dependence with one to two people for bed mobility and transfers.

On 7/19/21 at 11:03 AM, an observation was made of Resident #107 lying in bed. In the corner

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F 584	Continued From page 16 of the room, there was a large clear plastic garbage bag full of personal laundry. On 7/20/21 at 10:30 AM, during a wound care observation, the large clear plastic bag of personal laundry remained on the chair in the corner. On 7/20/21 at 10:30 AM, an interview was conducted with PCA #1. She stated she did not know why the clothes were on the chair. On 7/21/21 at 8:50 AM, the large clear plastic bag of personal laundry remained on the chair in the corner of the room. On 7/22/21 at 3:45 PM, an interview was conducted with the Assistant Director of Nursing. She stated it was the responsibility of the family members to put the residents clothing away.	F 584		
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information	F 636		8/17/21

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(ii) Customary routine.
(iii) Cognitive patterns.
(iv) Communication.
(v) Vision.
(vi) Mood and behavior patterns.
(vii) Psychological well-being.
(viii) Physical functioning and structural problems.
(ix) Continence.
(x) Disease diagnosis and health conditions.
(xi) Dental and nutritional status.
(xii) Skin Conditions.
(xiii) Activity pursuit.
(xiv) Medications.
(xv) Special treatments and procedures.
(xvi) Discharge planning.
(xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS).
(xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts.

§483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs.
(i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section,

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F 636	Continued From page 18 "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record reviews, the facility failed to complete an admission Minimum Data Set (MDS) assessment within 14 days of admission for 2 of 26 residents reviewed (Resident #313 and Resident #54). The findings included: 1.Resident #313 was admitted to the facility on 7/2/21 with diagnoses including, in part, cirrhosis and severe protein-calorie malnutrition. Resident #313's MDS assessments were reviewed. An entry tracker dated 7/2/21 was observed and had been submitted to Centers for Medicare & Medicaid Services (CMS). An admission assessment dated 7/9/21 had not been completed. An interview was conducted on 7/21/21 at 10:30 AM with MDS nurse #1 who stated Resident #313's admission MDS assessment should have been completed by 7/15/21. She stated they have been behind on all their assessments for about a month and added that corporate has recently begun providing additional help to complete all MDS assessments. An interview was conducted on 7/22/21 at 3:19 PM with the Director of Nursing (DON). She stated that the facility was aware that MDS was behind in completing assessments. The facility had worked on putting a system in place and had	F 636	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F 636 COMPREHENSIVE ASSESSMENT & TIMING Corrective Action: Resident #313. Admission Comprehensive Assessment, Assessment Reference Date (ARD) 7/9/2021. Completed, Submitted and Accepted on 7/28/2021 to the State Quality Improvement Evaluation System QIES system. Resident #54. Admission Comprehensive Assessment, Assessment Reference Date (ARD) 4/26/2021. Completed, Submitted and Accepted on 6/8/2021 to the State Quality Improvement Evaluation System QIES system. Identification of other residents who may be involved with this practice: All current residents with Comprehensive Minimum Data Set (MDS) assessments due have the potential to be affected by	

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F 636	Continued From page 19 recently rehired a previous employee to assist remotely to help complete assessments. The DON also explained the facility had received assistance from the corporate office as well. 2. Resident #54 was admitted to the facility on 8/3/17. His cumulative diagnoses included severe protein-calorie malnutrition and non-Alzheimer's dementia. Resident #54's Minimum Data Set (MDS) assessments included a comprehensive annual MDS dated 5/4/20. The resident ' s most recent comprehensive MDS was an annual assessment with an Assessment Reference Date (ARD) of 4/26/21. A review of the 4/26/21 annual MDS revealed the section on Assessment Administration was signed by a Registered Nurse (RN) verifying this assessment was completed on 6/7/21. An interview was conducted on 7/22/21 at 11:33 AM with MDS Nurse #1. During the interview, the MDS nurse reviewed Resident #54's annual MDS dated 4/26/21 and confirmed the assessment was signed and dated as having been completed on 6/7/21. She reported the assessment should have been completed 14 days after the ARD date of 4/26/21. MDS Nurse #1 stated the MDS was late because the facility's assessments were behind schedule.	F 636	the alleged practice. On 8/9/2021 an audit was completed by the MDS Nurse consultant to ensure that the facility had conducted a comprehensive, accurate, standardized reproducible assessment of each resident□s functional capacity. Out of the 107 current residents, 21 number of residents did not have their comprehensive assessments completed within 14 calendar days after admission, excluding readmission in which there is no significant change in the resident□s physical or mental condition. This assessments were completed by 8/12/2021. Systemic Changes: On 8/12-13/2021 The Registered Nurse (RN) Minimum Data Set (MDS) Coordinator, Licensed Practical Nurse (LPN) Minimum Data Set (MDS) Support nurses any other Interdisciplinary team member that participates in the MDS assessment process was in serviced /educated by the MDS nurse consultant. The education focused on: The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident□s functional capacity. OBRA-required comprehensive assessments include the completion of both the MDS and the CAA process, as well as care planning. Comprehensive assessments are completed upon admission, annually, and when a significant change in a resident□s status has occurred or a significant correction to a prior comprehensive assessment is required. They consist of: Admission	

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F 636	Continued From page 20 An interview was conducted on 7/22/21 at 3:19 PM with the facility's Director of Nursing (DON). During the interview, the DON reported the facility recognized the residents' MDS assessments were behind schedule. She stated the facility was working on putting a system in place to receive assistance and get caught up on their MDS assessments.	F 636	Assessment, Annual Assessment, and Significant Change in Status Assessment (SCSA)and Significant Correction to Prior Comprehensive Assessment (SCPA). The Admission assessment is a comprehensive assessment for a new resident and, under some circumstances, a returning resident that must be completed by the end of day 14, counting the date of admission to the nursing home as day 1 if: this is the resident□s first time in this facility, OR the resident has been admitted to this facility and was discharged return not anticipated, OR the resident has been admitted to this facility and was discharged return anticipated and did not return within 30 days of discharge. The Annual assessment is a comprehensive assessment for a resident that must be completed on an annual basis (at least every 366 days) unless a SCSA or a SCPA has been completed since the most recent comprehensive assessment was completed. Its completion dates (MDS/CAA(s)/care plan) depend on the most recent comprehensive and past assessments□ ARDs and completion dates.Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following:(i) Identification and demographic information(ii) Customary routine.(iii) Cognitive patterns.(iv) Communication.(v) Vision.(vi) Mood and behavior patterns.	

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F 636	Continued From page 21	F 636	(vii) Psychological well-being.(viii) Physical functioning and structural problems.(ix) Continence.(x) Disease diagnosis and health conditions.(xi) Dental and nutritional status.(xii) Skin Conditions. (xiii) Activity pursuit.(xiv) Medications. Special treatments and procedures.(xvi) Discharge planning.(xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS).(xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non licensed direct care staff members on all shifts. This in service was completed by 8/13/2021. Any MDS nurse (full time, part time, and PRN) and member of the interdisciplinary team who did not receive in-service training will not be allowed to work until training is completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Monitoring: To ensure compliance, The Director of Nursing and/or Mini Data Set (MDS) Coordinators will review weekly, 5 residents electronic records Mini Data Set(MDS) assessment this could be either one of the following Comprehensive assessments (Admission Assessment,	

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F 636	Continued From page 22	F 636	Annual Assessment, and Significant Change in Status Assessment and Significant Correction to Prior Comprehensive Assessment) to ensure that the comprehensive assessments are completed timely.This will be done on weekly basis to include the weekend for 4 weeks then monthly for 3 months. Reports will be presented to the weekly QA Committee by the Director of Nursing and/or Mini Data Set (MDS) Coordinators to ensure corrective action initiated as appropriate. Any immediate concerns will be brought to the Director of Nursing or Administrator for appropriate action. Compliance will be monitored and ongoing auditing program reviewed at the Weekly Quality of Life Meeting. Weekly QA Committee meeting is attended by Administrator, Director of Nursing, MDS Coordinator, Unit Manager, Support Nurse, Therapy, HIM, Dietary Manager, Wound Nurse.	
F 638 SS=D	Qrtly Assessment at Least Every 3 Months CFR(s): 483.20(c) §483.20(c) Quarterly Review Assessment A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on staff interviews and medical record review, the facility failed to complete a quarterly Minimum Data Set (MDS) assessment within 92 days of the Assessment Reference Date (ARD) of the previous MDS assessment for 3 of 26	F 638	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State	8/17/21

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	345284	A. BUILDING _____ B. WING _____	C 07/23/2021

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THE OAKS	901 BETHESDA ROAD WINSTON SALEM, NC 27103

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F 638	Continued From page 23 residents (Residents #1, #6 and #15) reviewed for timely completion of MDS assessments. The findings included: 1. Resident #1 was admitted to the facility on 2/3/2021 with diagnoses that included adult failure to thrive and Alzheimer's disease. A review of the Minimum Data Set (MDS) assessments for Resident #1 revealed the last assessment completed was an admission assessment completed on 2/10/2021. No other MDS assessments had been completed since 2/10/2021. The next quarterly MDS assessment had been scheduled for 5/13/2021. An interview was conducted with the MDS Coordinator on 7/22/2021 at 11:33 AM and she revealed the MDS assessments had been behind schedule. She added that the MDS staff had been assisting a sister facility that was recently acquired by the corporate company, to learn the new software. She stated the corporate company was now providing support to the MDS nurses and assisting with completing the assessments. This had been happening since the middle to end of June. The facility had one full time MDS nurse and one part time MDS nurse. An interview was conducted with the Director of Nursing (DON) on 7/22/2021 at 3:19 PM and she reported that the facility was aware, prior to the recertification survey, that the MDS assessments had been behind. The facility had been working on a system to get up to date and a previous employee had been contracted to assist remotely. The corporate company had also been working to provide assistance and additional education to	F 638	Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F 638 QRTLY ASSESSMENT AT LEAST EVERY 3 MONTHS Corrective Action: Resident #1. Quarterly Assessment, Assessment Reference Date (ARD) 5/132021. Completed, Submitted and Accepted on 8/10/2021 to the State Quality Improvement Evaluation System QIES system. Resident #6. Quarterly Assessment,, Assessment Reference Date (ARD) 6/18/2021. Completed, Submitted and Accepted on 8/6/2021 to the State Quality Improvement Evaluation System QIES system. Resident #15. Quarterly Assessment, Assessment Reference Date (ARD) 7/4/2021. Completed, Submitted and Accepted on 7/27/2021 to the State Quality Improvement Evaluation System QIES system. Identification of other residents who may be involved with this practice: All current residents with Quarterly Minimum Data Set (MDS) assessments due have the potential to be affected by the alleged practice. On 8/9/2021 an audit was completed by the MDS Nurse consultant to ensure that the facility had conducted Quarterly Review assessment of each resident□s. Out of the 107 current residents, 22 number of residents did not	

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F 638	Continued From page 24 the MDS nurses. 2. Resident #6 was admitted to the facility on 8/14/20 with diagnoses that included, in part, dementia and history of transient ischemic attack with cerebral infarction. A review of the quarterly MDS assessment dated 6/18/21 revealed that only sections C, D, E, and K were complete. Further review indicated that the assessment was to be completed by 7/2/21. The previous MDS assessment was completed and submitted on 3/18/21. An interview was conducted on 7/21/21 at 10:30 AM with MDS nurse #1 who agreed Resident #6's assessment should have been completed several weeks ago. She stated she is currently the only full-time MDS nurse at the facility and they have been behind for about a month now since corporate added on another facility whom they were helping complete their MDS as well. She added that corporate has recently began providing additional help to complete all MDS assessments. An interview was conducted on 7/22/21 at 3:19 PM with the Director of Nursing (DON). She stated that the facility was aware that MDS was behind in completing assessments. The facility had worked on putting a system in place and had recently rehired a previous employee to assist remotely to help complete assessments. The DON also explained the facility had received	F 638	have their quarterly review assessments completed within 92days since the ARD of the previous OBRA Quarterly Review Assessment or ARD of previous comprehensive assessment. This assessments were completed and submitted by 8/12/2021. Systemic Changes: On 8/12-13/2021 The Registered Nurse (RN) Minimum Data Set (MDS) Coordinator, Licensed Practical Nurse (LPN) Support nurses any other Interdisciplinary team member that participates in the MDS assessment process was in serviced /educated by the nurse consultant. The education focused on: The facility must conduct initially and periodically a Quarterly Review Assessment of each resident□s functional capacity. OBRA-required quarterly review assessments are to be completed within 92 days since the ARD of the previous OBRA Quarterly Review Assessment or ARD of previous comprehensive assessment, or significant Correction to Prior Quarterly Assessment (ARD of any of the mentioned assessments + 92 calendar days). The MDS completion date (item Z0500B must be no later than 14days after the ARD (ARD + 14 calendar days). This in service was completed by 8/13/2021. Any MDS nurse (full time, part time, and PRN) and member of the interdisciplinary team who did not receive in-service training will not be allowed to work until training is completed. This information has been integrated into the	

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F 638	Continued From page 25 assistance from the corporate office as well. 3. Resident #15 was admitted to the facility on 6/20/17 with diagnoses that included, in part, peripheral vascular disease. The quarterly MDS assessment with an ARD of 7/4/21 was reviewed. The computer system indicated the assessment was "in progress" and revealed sections A, B, H, I, J, L, M, N, O and P had not been completed. The system further indicated the assessment was due 7/18/21. The previous MDS assessment was completed on 4/3/21. An interview was completed with MDS Nurse #1 on 7/22/21 at 11:33 AM. She verified Resident #15's quarterly assessment should have been signed as completed by 7/18/21. She said the MDS assessments were behind schedule since MDS staff had assisted a sister facility who had recently switched to a new MDS software system. She added since the middle of June 2021 the corporate office had provided support to the MDS office and assisted in completing past due assessments. The corporate help was provided both remotely and onsite at the facility. The Director of Nursing (DON) was interviewed on 7/22/21 at 3:19 PM, during which she reported the facility recognized before the recertification survey that the MDS assessments were behind schedule. The facility had worked on putting a system in place and had contracted with a previous employee to remotely help with assessments. The DON explained the facility had received assistance from the corporate office	F 638	standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Monitoring: To ensure compliance, The Director of Nursing and/or Designee will review weekly, 5 residents electronic records Minimum Data Set(MDS) Quarterly assessments to ensure that the assessments are to be completed within 92days since the ARD of the previous OBRA Quarterly Review Assessment or ARD of previous comprehensive assessment, or significant Correction to Prior Quarterly Assessment (ARD of any of the mentioned assessments + 92 calendar days) and completed timely : the MDS completion date (item Z0500B must be no later than 14days after the ARD (ARD + 14 calendar days). This will be done on weekly basis to include the weekend for 12 weeks then monthly for 3 months. Reports will be presented to the weekly QA Committee by the Director of Nursing and/or Mini Data Set (MDS) Coordinators to ensure corrective action initiated as appropriate. Any immediate concerns will be brought to the Director of Nursing or Administrator for appropriate action. Compliance will be monitored and ongoing auditing program reviewed at the Weekly Quality of Life Meeting. Weekly QA Committee meeting is attended by Administrator, Director of Nursing, MDS Coordinator, Unit Manager, Support Nurse, Therapy, HIM, Dietary Manager, Wound Nurse.	

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F 638	Continued From page 26 in efforts to get caught up and had been re-educating the MDS nurses.	F 638		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessment in the areas of eating, transfers, toileting, and behaviors and skin conditions for 2 of 26 sampled residents (Residents #73 and 107). Findings included: 1. Resident #73 was originally admitted to the facility on 2/28/17 and re-admitted on 3/1/17 with diagnoses which included: vascular dementia with behavioral disturbance, hemiplegia and hemiparesis following cerebral infarction affecting the right dominant side. The 8/18/20 care plan revealed Resident #73 had episodes of displaying inappropriate behaviors: refusing to have blood drawn for laboratory testing at times; yelling out and screaming for no reason; and picking her face and arms until they bleed. The quarterly minimum data set (MDS) dated 5/18/21 indicated Resident #73 was moderately cognitively intact; had no behaviors, required extensive assistance of two staff for bed mobility,	F 641	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F641 Accuracy of Assessments Corrective Action: Resident # 73 Resident Minimum Data Set (MDS) assessment (Quarterly Assessment,) with Assessment /Reference Date (ARD) [5/18/2021] was modified. Resident # 107 Resident Minimum Data Set (MDS) assessment (Admission Comprehensive Assessment) with Assessment /Reference Date (ARD) [6/18/2021] was modified. Identification of other residents who may be involved with this practice: All current residents who have behavioral presence of symptoms during the Mini	8/17/21

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F 641	Continued From page 27 transfers, eating, and toileting; was always incontinent of bowel and bladder; and had range of motion impairment on one side of the upper and lower extremities. During an observation on 7/20/21 at 2:00 p.m., Resident #73 was asleep in a low bed. The resident was lying on her back and covered with a quilt. She appeared clean and dry with no odors. During an interview on 7/20/21 at 2:01 p.m., Nurse Aide (NA#1) stated Resident #73 required total assistance of two staff with all her activities of daily living (ADL), including bed mobility. She also revealed the resident required the use of a mechanical lift for transfers. NA#1 stated the resident would exhibit combative behaviors during ADL care and during incontinent care. She stated that during care the resident would bite, scratch, spit, yell and dig her fingernails into the skin of the staff. The NA also revealed when awake the resident would pick at her own skin. During an interview on 7/20/21at 2:34 p.m., Nurse #2 stated Resident #73 exhibited behaviors especially during care (scratching, biting, yelling). During an interview on 7/22/21 at 10:06 a.m., MDS Coordinator #1 acknowledged there were data entry errors on Resident #73's 5/18/21 MDS. She stated the resident required only one staff to assist the resident with eating; and, the resident should have been a total assist with transfers due to the resident required the use of a mechanical lift. However, MDS Coordinator #1 stated because the resident could occasionally inform staff when she had an incontinent accident, she was coded as requiring extensive assistance with toileting. MDS Coordinator #1 indicated the	F 641	Data Set (MDS) 7 day look back for quarterly assessment reference date(s); who requires activities of daily living assistance during the Mini Data Set (MDS) 7 day look back for quarterly assessment reference date(s), and who have wounds during the Mini Data Set (MDS) 7 day look back for admission assessment reference date(s), have the potential to be affected by the alleged practice. On 8/6/2021 through 8/10/2021 an audit was completed by the MDS Nurse Consultant to review all Quarterly Minimum Data Set (MDS) assessments in the last 6 months to ensure that all residents who have behavioral presence of symptoms during the Mini Data Set (MDS) 7 day look back is coded accurately. All assessments coded accurately. On 8/6/2021 through 8/10/2021 an audit was completed by the MDS Nurse Consultant to review all Quarterly Minimum Data Set (MDS) assessments in the last 6 months to ensure that all residents who requires activities of daily living assistance wounds during the Mini Data Set (MDS) 7 day look back is coded accurately. All assessments coded accurately. On 8/6/2021 through 8/10/2021 an audit was completed by the MDS Nurse Consultant to review all Quarterly Minimum Data Set (MDS) assessments in the last 6 months to ensure that all residents who have wounds during the Mini Data Set (MDS) 7 day look back for admission assessment reference date(s) is coded accurately. All assessments coded accurately. This was completed on 08/12/2021.	

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F 641	Continued From page 28 facility's Social Worker (SW) was responsible for the assessment and coding of the behavior section of the MDS. During an interview on 7/22/21 at 10:56 a.m., the SW stated his assessment and coding of Resident #73's behavior on the MDS was based on his observation and communication with the resident during the look back period of seven days or more. He stated that the resident was always cooperative during his questioning and answering period. He revealed he did not question staff about a resident's behaviors if the resident was able to communicate with him even if his/her responses were not always correct. 2. Resident # 107 was admitted to the facility on 6/18/21 with diagnoses of urinary retention and protein calorie malnutrition. An admission nursing assessment dated 6/18/21 at 10:57 AM revealed Resident #107 had a wound to his right and left scrotal areas and a wound to his medial and posterior penis. An admission Minimum Data Set (MDS) assessment dated 6/25/21 revealed Resident #107 had no ulcers, wounds, or skin problems. On 7/20/21 at 10:30 AM, Treatment Aide #1 was interviewed. He stated Resident #107 had the split to his penis and the scrotal breakdown on admission. On 7/22/21 at 3:19 PM, the Director of Nursing was interviewed. She stated she expected the MDS to be as accurate as possible as it was very important to help drive the plan of care.	F 641	Systemic Changes: On 8/12-13/2021 The Registered Nurse (RN) Minimum Data Set (MDS) Coordinator and MDS Support nurse and any other Interdisciplinary team member that participates in the MDS assessment process was in serviced /educated by the MDS Nurse consultant. The education focused on: The facility must ensure that each assessment accurately reflects the resident□s status. Section G: Functional Status within the 7day look back period. Review the documentation in the medical record for the 7-day look-back period. Talk with direct care staff from each shift that has cared for the resident to learn what the resident does for himself during each episode of each ADL activity definition as well as the type and level of staff assistance provided. Remind staff that the focus is on the 7-day lookback period only. When reviewing records, interviewing staff, and observing the resident, be specific in evaluating each component as listed in the ADL activity definition. For example, when evaluating Bed Mobility, observe what the resident is able to do without assistance, and then determine the level of assistance the resident requires from staff for moving to and from a lying position, for turning the resident from side to side, and/or for positioning the resident in bed. Section E: Behavioral Symptoms : Review the medical record for the 7-day look-back period. Interview staff, across all shifts and disciplines, as well as others who had	

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F 641	Continued From page 29 On 7/22/21 at 3:30 PM, MDS Nurse #1 stated when Resident #107's MDS was completed, there was only an order for a cream to be applied. MDS Nurse #1 stated she did not complete Resident #107's MDS assessment but the resident's skin should have been examined at the time of the assessment.	F 641	close interactions with the resident during the 7-day look-back period, including family or friends who visit frequently or have frequent contact with the resident. Observe the resident in a variety of situations during the 7-day look-back period. Section M: Other Ulcers, Wounds and Skin Problems. Review the medical record, including skin care flow sheets or other skin tracking forms. Speak with direct care staff and the treatment nurse to confirm conclusions from the medical record review. Examine the resident and determine whether any ulcers, wounds, or skin problems are present. " Key areas for diabetic foot ulcers include the plantar (bottom) surface of the foot, especially the metatarsal heads (the ball of the foot). if there is no evidence of such problems in the last 7 days, check none of the above. This in service was completed by 8/13/2021. The Registered Nurse (RN) and or Licensed Practical Nurse (LPN) Support Minimum Data Set (MDS) Coordinators and any other Interdisciplinary team member that participates in the MDS assessment process who did not receive in-service training will not be allowed to work until training is completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Monitoring: To ensure compliance, The Director of Nursing and/or Administrator will review 5	

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F 641	Continued From page 30	F 641	resident electronic medical records Minimum Data Set (MDS) assessment this could be either one of the following assessments Admission, Annual or Quarterly Assessment to ensure that section Section G: Functional Status within the 7day look back period, Section E: Behavioral Symptoms, and Section M: Other Ulcers, Wounds and Skin Problems. are coded accurately. This will be done on weekly basis for 4 weeks then monthly for 3 months. The results of this audit will be reviewed at the weekly QA Team Meeting. Reports will be presented to the weekly QA Committee by the Director of Nursing and/or Mini Data Set (MDS) Coordinators to ensure corrective action initiated as appropriate. Any immediate concerns will be brought to the Director of Nursing or Administrator for appropriate action. Compliance will be monitored and ongoing auditing program reviewed at the Weekly Quality of Life Meeting. Weekly QA Committee meeting is attended by Administrator, Director of Nursing, MDS Coordinator, Unit Manager, Support Nurse, Therapy, HIM (Health Information Management), Dietary Manager, Wound Nurse.	
F 655 SS=E	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide	F 655		8/17/21

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F 655	Continued From page 31	F 655		

effective and person-centered care of the resident that meet professional standards of quality care.
The baseline care plan must-
(i) Be developed within 48 hours of a resident's admission.
(ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to-
(A) Initial goals based on admission orders.
(B) Physician orders.
(C) Dietary orders.
(D) Therapy services.
(E) Social services.
(F) PASARR recommendation, if applicable.

§483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan-
(i) Is developed within 48 hours of the resident's admission.
(ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).

§483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to:
(i) The initial goals of the resident.
(ii) A summary of the resident's medications and dietary instructions.
(iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility.
(iv) Any updated information based on the details of the comprehensive care plan, as necessary.
This REQUIREMENT is not met as evidenced by:
Based on staff interviews and record reviews, the

The statements made on this plan of

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F 655	Continued From page 32 facility failed to develop a baseline care plan within 48 hours of the resident's admission for 4 of 9 newly admitted residents reviewed (Resident #416, Resident #415, Resident #413, and Resident #313). The findings included: 1. Resident #416 was admitted to the facility on 7/9/21. Her cumulative diagnoses included Type 2 diabetes with chronic kidney disease. The resident's electronic medical record (EMR) included a baseline care plan dated 7/12/21. This baseline care plan was not completed within 48 hours of the resident's admission. An interview was conducted on 7/21/21 at 10:20 AM with the facility's Minimum Data Set (MDS) Nurse #1. During the interview, the MDS Nurse reviewed Resident #416's EMR and confirmed her baseline care plan was dated 7/12/21. MDS Nurse #1 reported the facility utilized the Physician Order Summary as the baseline care plan for newly admitted residents. She stated the resident's comprehensive care plan would be created when his/her MDS assessment was worked on. An interview was conducted on 7/21/21 at 2:02 PM with the facility ' s Assistant Director of Nursing (ADON). The ADON reported the nurse who verified a resident ' s medications on the day of admission would be responsible to print up the baseline care plan. The ADON reported that if she was working, she would put the admission orders into the EMR and complete the baseline care plan herself. The ADON reported the facility was aware of the 48-hour requirement to	F 655	correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F655 1. Corrective action for resident(s) affected by the alleged deficient practice: Resident #416 was discharged from the facility on 07.26.2021. Prior to discharge the Baseline Care Plan was printed, reviewed with the resident, and a copy was provided to the resident on 07.12.2021. Resident #415□s Baseline Care Plan was printed, reviewed with the resident representative, and a copy was provided to the resident representative on 07.12.2021. Resident #413 was discharged from the facility on 07.20.2021. Prior to discharge the Baseline Care Plan was printed, reviewed with the resident representative, and a copy was provided to the resident representative on 07.21.2021. Resident #313 was discharged from the facility on 07.19.2021. Prior to discharge the Baseline Care Plan was printed, reviewed with the resident, and a copy	

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F 655	Continued From page 33 complete an initial baseline care plan for new admissions. An interview was conducted on 7/22/21 at 3:19 PM with the facility's Director of Nursing (DON). During the interview, the DON reported she had been made aware of the concerns regarding residents' baseline care plans not being completed within 48 hours of admission. She stated the facility found some residents who were admitted on a Friday were not getting a baseline care plan completed until the ADON came in on Monday. The DON reported the facility was reviewing and revising the system in place to ensure the timely initiation of baseline care plans. 2. Resident #415 was admitted to the facility on 7/9/21. His cumulative diagnoses included Type 2 diabetes with long term (current) use of insulin and Parkinson's dementia. The resident's electronic medical record (EMR) included a baseline care plan dated 7/12/21. This baseline care plan was not completed within 48 hours of the resident's admission. An interview was conducted on 7/21/21 at 2:02 PM with the facility's Assistant Director of Nursing (ADON). The ADON reported the nurse who verified a resident's medications on the day of admission would be responsible to print up the baseline care plan. The ADON reported that if she was working, she would put the admission orders into the EMR and complete the baseline care plan herself. The ADON reported the facility was aware of the 48-hour requirement to complete an initial baseline care plan for new admissions.	F 655	was provided to the resident on 07.05.2021. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. Beginning on 07.23.2021, The Director of Nurses (DON) initiated an audit of all current residents admitted during the last 14 days to identify any residents who did not have a base line care plan developed within 48 hours of the resident□s admission and where there was no summary provided to the resident and/or resident representative. The audit was completed on 07.23.2021. Results: 2 of 18 residents did not have base line care plan developed with 48 hours. All residents or resident representatives were provided with a summary of the baseline care plan. 3. Measures/Systemic changes to prevent reoccurrence of alleged deficient practice: Education: On 08.13.2021, the DON began reeducating Assistant Director of Nursing, Registered Nurse Weekend Supervisor, Licensed Practical Nurse Evening Supervisor on the following topics: " Timeline for Initiating a Base Line	

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F 655	Continued From page 34 An interview was conducted on 7/22/21 at 3:19 PM with the facility's Director of Nursing (DON). During the interview, the DON reported she had been made aware of the concerns regarding residents' baseline care plans not being completed within 48 hours of admission. She stated the facility found some residents who were admitted on a Friday were not getting a baseline care plan completed until the ADON came in on Monday. The DON reported the facility was reviewing and revising the system in place to ensure the timely initiation of baseline care plans. 3. Resident #413 was admitted to the facility on 7/16/21. Her cumulative diagnoses included fibromyalgia. A review of the resident's electronic medical record (EMR) conducted on 7/19/21 revealed there was no baseline care plan in the EMR. An interview was conducted on 7/21/21 at 10:20 AM with the facility's Minimum Data Set (MDS) Nurse #1. During the interview, the MDS Nurse reviewed Resident #413's medical record and confirmed the resident's baseline care plan was yet not in her EMR. MDS Nurse #1 reported the facility utilized the Physician Order Summary as the baseline care plan for newly admitted residents. She stated the resident's comprehensive care plan would be created when his/her MDS assessment was worked on. An interview was conducted on 7/21/21 at 2:02 PM with the facility's Assistant Director of Nursing (ADON). The ADON reported the nurse who verified a resident's medications on the day of admission would be responsible to print up the baseline care plan. The ADON reported that if	F 655	Care Plan " Review of the Base Line Care Plan Requirements This information has been integrated into the standard orientation training and will be reviewed by the Quality Assurance process to verify that the change has been sustained. As of 08.17.2021, any staff who does not receive scheduled in-service training will not be allowed to work until training has been completed. The facility will review this information in their clinical meeting and discuss any issues at least weekly for the next 3 months unless the Quality Assurance Committee feels this issue has been resolved sooner. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Director of Nursing or designee will monitor compliance utilizing the F655 Quality Assurance Tool weekly x 4 weeks then monthly x 3 months. The DON or designee will monitor for compliance with initiating base line care plans within the specified time frame and provide the resident and/or their representative with a summary of the baseline care plan. Reports will be presented to the weekly Quality Assurance (QA) committee by the DON to ensure corrective action is initiated as appropriate. Compliance will	

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F 655	Continued From page 35 she was working, she would put the admission orders into the EMR and complete the baseline care plan herself. Upon inquiry, the ADON stated she recalled talking with Resident #413 on 7/19/21 but acknowledged this would have been outside the 48-hour window for completion of her baseline care plan. An interview was conducted on 7/22/21 at 3:19 PM with the facility's Director of Nursing (DON). During the interview, the DON reported she had been made aware of the concerns regarding residents' baseline care plans not being completed within 48 hours of admission. She stated the facility found some residents who were admitted on a Friday were not getting a baseline care plan completed until the ADON came in on Monday. The DON reported the facility was reviewing and revising the system in place to ensure the timely initiation of baseline care plans. 4. Resident #313 was admitted to the facility on 7/2/21 with diagnoses, in part, degenerative disease of the liver and severe protein-calorie malnutrition. The resident's electronic medical record (EMR) included a baseline care plan dated 7/5/21. This baseline care plan was not completed within 48 hours of the resident's admission. An interview was conducted on 7/21/21 at 10:15 AM with the facility's Assistant Director of Nursing (ADON). The ADON reported that if she was working, she would print the baseline care plan for the resident or responsible party to sign. She stated that the date shown on the baseline care plan was when it was printed out for review and	F 655	be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nurses, Assistant Director of Nurses, Minimum Data Set Nurses, Therapy Manager, RN Unit Manager, Unit Support Nurses, Health Information Manager, and the Dietary Manager. Date of Compliance: 08.17.2021	

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F 655	Continued From page 36 signature. The ADON agrees that Resident #313's printed date was outside the 48-hour window for completion of his baseline care plan. An interview was conducted on 7/22/21 at 3:26 PM with the facility's Director of Nursing (DON). During the interview, the DON reported she had been made aware of some baseline care plans not being completed within 48 hours of admission. She stated the facility found some residents who were admitted on a Friday were not getting a baseline care plan completed until the ADON came in on Monday. The DON reported the facility was reviewing and revising the system in place to ensure the timely initiation of baseline care plans.	F 655		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to provide a treatment for 6 days to a non-pressure wound for 1 of 5 residents reviewed for pressure ulcers (Resident #107). The findings included:	F 684	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction	8/20/21

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F 684	Continued From page 37	F 684		

Resident # 107 was admitted to the facility on 6/18/21 with a diagnosis of urinary retention.

An admission nursing assessment dated 6/18/21 revealed Resident #107 had a wound to his scrotal area and on the medial and posterior aspect of his penis.

A review of the care plan dated 6/22/21 revealed a focus area of risk for pressure ulcer development; had a small split-like area on penis due to catheter and a wound to his scrotal area. Interventions included treatment to penis as ordered and monitor for infection.

An admission Minimum Data Set (MDS) assessment dated 6/25/21 revealed Resident #107 was cognitively impaired. The MDS indicated Resident #107 had no wounds or skin problems.

A review of the physician's orders for June 2021 revealed no treatment was started for the wound to Resident #107's penis until 6/23/21.

On 7/20/21 at 10:30 AM, an observation of Resident #107's skin was conducted. Resident #107 had an opening on his penis from the top to approximately midway down to the base. Resident #107 had an indwelling catheter in place.

On 7/20/21 at 10:30 AM, an interview was conducted with the Treatment Aide. He stated Resident #107 was admitted to the facility with the open area to his penis.

On 7/21/21 at 7:20 AM, an interview was conducted with the Treatment Nurse. She stated

constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated.
F684
1. Corrective action for resident(s) affected by the alleged deficient practice:

Resident #107, discharged from the facility on 08.07.2021, therefore no corrective action could be completed for him. Treatment orders were initiated on 06.23.2021 for him prior to his discharge. Resident received wound care as ordered once the treatment order was initiated.

2. Corrective action for residents with the potential to be affected by the alleged deficient practice.

On 07.27.2021, the treatment nurse audited all new admit residents requiring wound care and any newly identified facility wounds for the last 14 days from 07.23.2021 to ensure that each resident had wound treatment orders initiated in a timely manner to ensure that residents receive treatment and care in accordance with professional standards of practice. This was completed on 07.28.2021.

3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice:

On 07.23.2021, the DON, Treatment Nurse, Administrator, and the Quality Assurance Clinical Nurse Consultant reviewed the policy on wound

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F 684	Continued From page 38 Resident #107 was admitted to the facility with the open area to his penis. She stated the admitting nurse was supposed to complete a skin assessment and if there were any areas, they were to fill out a new skin development tracking tool. They were supposed to also call the physician and get an order to initiate a treatment. She stated she did not receive the form for Resident #107, so she was unaware he had any skin issues. She stated she found out on 6/23/21 and called the physician to obtain an order. On 7/22/21 at 4:18 PM, an interview was conducted with the DON. She stated Resident #107 was admitted with the open area to his penis. The DON added the nurse that completed the admission assessment needed further education in describing skin issues.	F 684	documentation. There were no changes required for the policy. On 07.25.2021, the Director of Nursing (DON) began reeducating all Licensed Nurses, Registered Nurses, Licensed Practical Nurses, and any Treatment Aides, full time, part time, agency staff, and PRN on the following topics: " What to do when wounds are identified " Timely Wound Assessment " Proper Treatment of wounds This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. Any staff who does not receive scheduled in-service training will not be allowed to work until training has been completed by 08.20.2021. The facility will review this information in their clinical meeting and discuss any issues at least weekly for the next 3 months unless the Quality Assurance Committee feels this issue has been resolved sooner. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The DON or designee will monitor compliance utilizing the F684 Quality Assurance Tool weekly x 4 weeks then	

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F 684	Continued From page 39	F 684	monthly x 3 months. The DON will monitor compliance to ensure that each resident had wound treatment orders initiated in a timely manner to ensure that residents receive treatment and care in accordance with professional standards of practice. Reports will be presented to the weekly Quality Assurance committee by the DON to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance (QA) Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Coordinator, Unit Support Nurses, Therapy Manager, Health Information Manager, and the Dietary Manager.	
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on staff interviews, and record reviews,	F 686	The statements made on this plan of	8/20/21

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F 686	Continued From page 40 the facility failed to ensure skin breakdown was identified and treated for 1 of 6 residents (Resident #317) reviewed for pressure ulcers. Findings included: Resident #317 was admitted to the facility on 8/12/19 from a hospital with the following, in part, diagnoses: hypertension, severe protein malnutrition, type 2 diabetes mellitus, and cardiomyopathy. Resident #317's admitting Minimum Data Set (MDS) dated for 11/28/19 showed no pressure ulcers or skin breakdown under section M. It also revealed that he required one person assistance for bed mobility, transfers, and toileting. A record review on 7/20/21 showed a nurse note dated 1/21/20 @ 10:49 PM written by Nurse #5 stating that she observed an open area to upper intergluteal cleft. The area was cleansed with wound cleaner and foam applied. The note also stated that Resident #317 was provided with a wedge cushion to place under left buttock to relieve pressure. There was no further documentation found regarding this wound until 1/28/21. A review of a 1/22/20 weekly skin check states there are no new skin area concerns. Interview on 7/21/21 at 2:20 PM with Nurse #1 revealed that when a wound is identified, the nurse will put the information in "a book" at the nurse's station for a wound to be assessed by the treatment team and orders be made if necessary. She admitted that this book is not kept as part of the medical record nor did she remember if she	F 686	correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F686 1. Corrective action for resident(s) affected by the alleged deficient practice: Resident #317, discharged from the facility on 02.03.2020, therefore no corrective action could be completed for him. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. On 07.27.2021, the treatment nurse audited all new admit residents requiring wound care and any newly identified facility wounds for the last 14 days to ensure that each resident receives necessary treatment and services, consistent with professional standards of practice to promote healing, prevent infection, and prevent new ulcers from developing. This was completed on 07.28.2021. 3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice:	

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F 686	Continued From page 41 did that for this resident. She was unable to provide a clear explanation as to why the weekly skin check done the following day stated that he had no new skin area concerns. Interview on 7/22/21 at 9:45 AM with the Treatment Aide who was unable to locate any treatment orders for Resident #317 whom he remembers but does not recall doing any treatments for him during his time at the facility. He stated that the staff will normally put a note in a book that he checks at the nurse's station and then the treatment team will assess the resident for any possible intervention. An interview was conducted on 7/22/21 at 12:22 PM with the facility's Director of Nursing (DON). She provided me with a skin and wound evaluation dated for 1/28/20 stating Resident #317's buttock wound was as follows: 4.3 x 3.1 cm; Stage 2, 70% granulation and 30% eschar. She stated that she did not know what the documentation from 1/21/20 by Nurse #1 was all about. She also stated that resident was referred to the wound clinic on 1/28/20 when the issue was identified but never made it there because he was discharged on 2/3/20 to the hospital for a different concern. She was unable to provide any documentation that any care was done for the wound for the 6 days between 1/28/20 and his discharge from the facility on 2/3/20 either. She stated that their current process for addressing new and potential wounds on residents will become part of their quality process improvement meetings.	F 686	On 07.23.2021, the Director of Nursing (DON), Treatment Nurse, Administrator, and the Quality Assurance Clinical Nurse Consultant reviewed the policy on wound documentation. There were no changes required for the policy. On 07.25.2021, the Director of Nursing (DON) began educating all Licensed Nurses, Registered Nurses, Licensed Practical Nurses, and any Treatment Aides, full time, part time, agency staff, and PRN on the following topics: " What to do when wounds are identified " Timely Wound Assessment " Proper Treatment of wounds This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. Any staff who does not receive scheduled in-service training will not be allowed to work until training has been completed by 08.20.2021. The facility will review this information in their clinical meeting and discuss any issues at least weekly for the next 3 months unless the Quality Assurance Committee feels this issue has been resolved sooner. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory	

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F 686	Continued From page 42	F 686	requirements. The DON or designee will monitor compliance utilizing the F686 Quality Assurance Tool weekly x 4 weeks then monthly x 3 months. The DON will monitor compliance to ensure that each resident receives necessary treatment and services, consistent with professional standards of practice to promote healing, prevent infection, and prevent new ulcers from developing. Reports will be presented to the weekly Quality Assurance committee by the DON to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance (QA) Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Coordinator, Unit Support Nurses, Therapy Manager, Health Information Manager, and the Dietary Manager.	
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to	F 688		8/20/21

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 688	Continued From page 43 prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to apply a resting right hand splint (Resident #22) and a right hand and right leg splint (Resident #38) for 2 of 2 residents reviewed for contracture management. 1. Resident #22 was admitted to the facility on 7/17/20 with hemiplegia. A quarterly Minimum Data Set (MDS) assessment dated 4/24/21 revealed Resident #22 had severely impaired cognition, required extensive assistance of two people for most of her activities of daily living and had a limitation in range of motion to her upper and lower extremity on one side. The care plan dated 1/22/21 revealed a focus area of right resting hand splint application due to hand contracture. The goal was for Resident #22 to wear a right resting hand splint for approximately 2 hours a day to minimize the risk for further decline in range of motion. Splint to be applied and removed as scheduled by nursing staff or restorative aide. The physician's orders revealed an order dated 4/19/21 that read "patient to wear right functional positioning splint approximately 2 hours a day as donned and doffed by nursing and/or restorative	F 688	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F688 1. Corrective action for resident(s) affected by the alleged deficient practice: Resting right-hand splint was applied for Resident #22. Therapy screened this resident on 08.16.2021, there was no reduction in the range of motion observed for this resident. Right hand and right leg splint was applied for Resident #38. Therapy screened this resident on 08.16.2021, there was no reduction in the range of motion observed for this resident. 2. Corrective action for residents with the potential to be affected by the alleged	

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F 688	Continued From page 44 staff." An occupational therapy screen was conducted on 7/12/21 at 12:01 PM. The screening was conducted for a quarterly review. The screen indicated Resident #22 had increased tone in her right hand and had a splint. The screen further indicated Resident #22 was currently on a restorative or maintenance program and recommended to continue restorative nursing program for splinting. An occupational therapy evaluation was not indicated due to no change in level of function. A Restorative Nursing Review dated 7/20/21 indicated Resident #22 was on a restorative program of splinting with skin checks. The note read: "resident tolerates application/removal well. Denies pain. No skin issues reported." The plan was to continue current program with existing goals. An observation on 7/21/21 at 12:45 PM revealed Resident #22 did not have a right resting hand splint in place. An observation on 7/22/21 at 1:42 PM revealed Resident #33 did not have a right resting hand splint in place. On 7/20/21 at 2:47 PM, an interview was conducted with Restorative Aide #1 who stated she did not apply Resident #22's splint because she did not have her on her caseload. She further stated she did not have Resident #22's restorative orders in her chart application. She added she thought therapy was still seeing Resident #22.	F 688	deficient practice. On 08.16.2021, the Director of Nursing (DON) audited 100% of all residents with orders for splints to ensure that there are orders in place to apply the splint. Results: 15 of 15 residents with splints had orders to apply the splints. On 08.16.2021, the Director of Nursing audited 100% of all residents with orders for splints to ensure that there is a Certified Nursing Assistant (C N A) task for the restorative aides to apply the splint. Results: 15 of 15 residents with splints had CNA task to apply the splints. On 08.16.2021, the Minimum Data Set Coordinator ensured that all Care plans were updated to reflect the splint use. The restorative team met on 08.16.2021 to discuss ways to better communicate any changes in treatment plan. 3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: On 07.23.2021, the Director of Nursing (DON), Treatment Nurse, Administrator, and the Quality Assurance Clinical Nurse Consultant reviewed the policy on restorative nursing – Range of Motion (ROM) contractures. There were no changes required for the policy. On 07.25.2021, the Director of Nursing (DON) began reeducating all Licensed Nurses (Registered Nurses and Licensed	

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F 688	Continued From page 45 On 7/22/21 at 2:32 PM, Nurse #5 was interviewed. She stated she was responsible for completing the Restorative Nursing Review note of residents receiving restorative care by Restorative Aide #1. She stated she received a list from the therapy department on 6/11/21 and Resident #22 was on the list for splinting, so she assumed she was still having it applied. She stated she did not receive any communication from Restorative Aide #1 that Resident #22 was not receiving the splint. She further stated she completed the Restorative Nursing Review note every Friday by answering questions such as: "type of restorative received, how procedure tolerated, and continue or change activity" without direct knowledge and basing accuracy on not receiving any report that indicated otherwise. 2. Resident #38 was admitted to the facility on 8/21/20 with the diagnoses which included hemiplegia and hemiparesis following cerebral infarction affecting the right side, contractures, and aphasia. The current care plan dated 12/22/20 revealed Resident #38 had the diagnoses of right hemiplegia related to a cerebral vascular accident; and right upper extremity and right lower extremity contractures requiring splinting application. Approaches included: apply splints to right hand and right leg daily; remove hand splint at night; remove knee splint after 2-3 hours; wash/clean skin, nails after removal; and reposition the resident as tolerated and at least every 2 hours. During an interview on 7/22/21 at 1:37 p.m., the Occupational Therapist (OT) stated Resident	F 688	Practical Nurses), and Certified Nursing Assistants (CNA) full time, part time, agency staff, and PRN on the following topics: • Guidelines for the restorative ROM program • What to do if there is a change in the resident's ROM • Who to contact in the event of any issues related to restorative program. • Staff was educated on applying splints per schedule and documenting instances of resident non – compliance. • All CNA's and nurses will be in-serviced on the proper use and application of splints and documenting. • Education on alerting supervisor if unable to provide scheduled Restorative Program on any day scheduled was provided to Restorative Aide. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. Any staff who does not receive scheduled in-service training will not be allowed to work until training has been completed by 08.20.2021. The facility will review this information in their clinical meeting and discuss any issues at least weekly for the next 3 months unless the Quality Assurance Committee feels this issue has been resolved sooner.	

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F 688	Continued From page 46 #38's most recent quarterly OT assessment was 4/20/21 which showed no change in her condition with no new recommendations at that time. She revealed the resident received physical therapy from 4/15/21 through 5/11/21 for contracture management using range of motion manual technique for the right lower extremity. The resident was discharged from therapy with the recommendation for the restorative program for contracture prevention. The OT stated Resident #38 also received restorative for splinting using a knee extension splint and a hand splint The quarterly minimum data set dated 5/11/21 indicated Resident #38 was severely, cognitively impaired .and had range of motion impairment of the upper extremity on one side and lower extremities on both sides. During an interview on 7/22/21 at 3:06 p.m., the RNA revealed Resident #38 was not receiving restorative treatments. She stated after receiving the training with the occupational therapist, she began working with the resident in the middle of May 2021 on range of motion and splinting of the right leg and, range of motion and application of the hand splint to the right hand, for the duration of 3-4 hours per day, Monday through Friday. But after noticing that the hand splinting and hand range of motion was not in the charting application, the RNA stated she discontinued the exercise and reported this to the nurse. The RNA stated she continued leg splinting treatment with the resident until sometime in June 2021 when Resident #38 could no longer endure the pain of the leg extending required when applying the leg splint. She revealed she reported the resident's excruciating pain and her decision to discontinue the treatment to several nursing staff including	F 688	4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The DON or designee will monitor compliance utilizing the F688 Quality Assurance Tool weekly x 4 weeks then monthly x 3 months. The DON will monitor compliance to ensure that residents who have orders for splinting and range of motion are receiving the recommended services to increase range of motion and/or to prevent further decrease in range of motion. The audit will observe random residents for compliance with their splint use. Reports will be presented to the weekly Quality Assurance (QA) committee by the DON to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Coordinator, Unit Support Nurses, Therapy Manager, Health Information Manager, and the Dietary Manager.	

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F 688	Continued From page 47	F 688		

therapy who indicated they would investigate it. She stated Resident #38 had not received any restorative services since June 2021.

The updated care plan dated 6/10/21 revealed Resident #38 was to receive restorative nursing for splinting application. Approaches included assist with application and removal of splint according to schedule.

On 7/22/21 at 2:32 p.m., an interview with Nurse #5 revealed she was responsible for completing the Restorative Nursing Review Notes of residents receiving restorative care by the restorative nurse aide (RNA). She further explained that all restorative exercises and splinting applications were done during first shift, Monday through Friday. Nurse #5 revealed that prior to this interview she was informed by the RNA that she had discontinued the application of the knee splint to Resident #38's leg due to the severity of her contractures. Nurse #5 stated because she was unaware of this, she had been completing the Restorative Review form every Friday indicating Resident #38 tolerated the restorative treatment. When questioned on the data/report used to complete the Restorative Nursing Review Note for Resident #38, Nurse #5 acknowledged she completed the review without direct knowledge and based accuracy on not receiving any report indicating otherwise. Nurse #5 stated most days she did not communicate with the RNA and was unaware if the RNA documented her restorative visits or where such documents were maintained.

During an observation on 7/19/21 at 11:48 a.m., Resident #38 was reclining in bed with the head of bed up at approximately 80 degrees and both

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F 688	Continued From page 48 arms lying on top of the bed covers. The resident's right hand was bent forward at the wrist with the fingers folded toward the right palm. The resident was non-verbal but when asked if she could open her hand, she slightly nodded no.	F 688		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to discard expired medications stored in 3 of 3 medication carts (200 Hall Med	F 761	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the	8/20/21

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F 761	Continued From page 49 Cart, 500 Hall Med Cart, and 400 Hall Med Cart) and in 1 of 2 medication rooms (200/300 Hall Med Room) observed. The findings included: 1-a) In the presence of Nurse #3, an observation was conducted of the 200 Hall Med Cart on 7/20/21 at 2:50 PM. The observation revealed an opened insulin lispro prefilled pen dispensed for Resident #61 was stored on the med cart. The insulin pen was noted to have been opened on 6/11/21. An interview was conducted with the Nurse #3 on 7/20/21 at 2:55 PM. Upon review of the opened insulin lispro prefilled pen, the nurse confirmed the insulin pen was expired. A review of the manufacturer's storage instructions indicated insulin lispro prefilled pens that have been opened (in use) should be stored at room temperature and used within 28 days. An interview was conducted on 7/21/21 at 10:10 AM with the facility's Director of Nursing (DON). The findings of the Medication Storage task were discussed during the interview. When asked, the DON stated she would expect staff to watch for expired insulin and remove it from the med cart when the insulin was expired. 1-b) In the presence of Nurse #3, an observation was conducted of the 200 Hall Med Cart on 7/20/21 at 2:50 PM. The observation revealed an opened insulin lispro prefilled pen dispensed for Resident #14 was stored on the med cart. The insulin pen was noted to have been opened on 6/14/21.	F 761	alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F761 1. Corrective action for resident(s) affected by the alleged deficient practice: Resident #61, the Insulin Lispro pen was removed from the cart and discarded. A new Insulin Lispro pen was obtained and dated when opened for this resident on 07.20.2021. Resident #14, the Insulin Lispro pen was removed from the cart and discarded. A new Insulin Lispro pen obtained and dated when opened for this resident on 07.20.2021. Resident #79, the Insulin Lispro pen was removed from the cart and discarded. A new Insulin Lispro pen obtained and dated when opened for this resident on 07.20.2021. Resident #101 was discharged on 06.23.2021, therefore no corrective action could be completed for him. Resident #418 discharged 6.12.21, therefore no corrective action could be completed for her, medication removed from cart 7.20.21.	

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F 761	Continued From page 50 An interview was conducted with the Nurse #3 on 7/20/21 at 2:55 PM. Upon review of the opened insulin lispro prefilled pen, the nurse confirmed the insulin pen was expired. A review of the manufacturer's storage instructions indicated insulin lispro prefilled pens that have been opened (in use) should be stored at room temperature and used within 28 days. An interview was conducted on 7/21/21 at 10:10 AM with the facility's Director of Nursing (DON). The findings of the Medication Storage task were discussed during the interview. When asked, the DON stated she would expect staff to watch for expired insulin and remove it from the med cart when the insulin was expired. 2. In the presence of Nurse #1, an observation was conducted of the 500 Hall Med Cart on 7/20/21 at 8:10 AM. The observation revealed an opened Novolog insulin pen dispensed for Resident #79 was stored on the med cart. The handwritten date on insulin pen indicated the pen had been opened on either 6/8/21 or 6/9/21. Upon request, Nurse #1 reviewed the labeling on the Novolog insulin pen. She reported the date opened was 6/8/21 or 6/9/21. A review of the manufacturer's storage instructions indicated Novolog insulin prefilled pens that have been punctured (in use) should be stored at room temperature and used within 28 days. A follow-up observation and interview were conducted on 7/20/21 at 12:55 PM with Nurse #1. At that time, the Novolog insulin pen for Resident	F 761	On 07.20.2021, the Director of Nurses (DON) ensure that all expired medications were removed and discarded from the cart. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents in the facility who take medications have the potential to be affected. Beginning on 08.12-13.2021, the Night Shift LPNs audited all medication carts, treatment carts, and medication rooms to identify any expired or undated medications. Corrections were made immediately where indicated. This was completed on 08.12-13.2021. No resident was found to be affected by the deficient practice. In order to ensure that no resident was affected, a continued weekly review of the facility medication carts and treatment carts was conducted by the DON, Unit Support Nurses, and the Weekend RN Supervisor to ensure there were no medications beyond the expiration date and that there were no undated medications in the cart. Corrections were made immediately where indicated. This was completed on 08.12-13.2021. 3. Measures/Systemic changes to prevent reoccurrence of alleged deficient practice: Education: On 07.23.2021, the DON, Treatment	

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F 761	Continued From page 51 #79 was observed to remain on the med cart. When asked, the nurse reported the insulin pen was good for 28-30 days. Upon further inquiry, Nurse #1 reported the Novolog insulin pen was expired and needed to be pulled off of the medication cart. An interview was conducted on 7/21/21 at 10:10 AM with the facility's Director of Nursing (DON). The findings of the Medication Storage task were discussed during the interview. When asked, the DON stated she would expect staff to watch for expired insulin and remove it from the med cart when the insulin was expired. 3. In the presence of Nurse #2, an observation was conducted of the 400 Hall Med Cart on 7/20/21 at 8:40 AM. The observation revealed a medication bottle labeled as "GI Cocktail 4:1" dispensed from the pharmacy for Resident #418 was stored on the med cart. The expiration date on the label of the medication bottle was 6/16/21. Upon inquiry, Nurse #2 stated the medication shouldn't have been on the med cart. A follow-up interview was conducted on 7/20/21 at 12:55 PM with Nurse #2. During the interview, the nurse reported she had placed the expired bottle of the GI Cocktail 4:1 in the pharmacy tote to be returned to the pharmacy. An interview was conducted on 7/21/21 at 10:10 AM with the facility's Director of Nursing (DON). The findings of the Medication Storage task were discussed during the interview. When asked, the DON stated she would expect staff to watch for expired medications and to remove them from the med cart.	F 761	Nurse, Administrator, and the Quality Assurance Clinical Nurse Consultant reviewed the policy on McNeill□s Long-Term Pharmacy Recommended Storage for Selected Items. There were no changes required for the policy. On 07.25.2021, the DON began educating all full time, part time, agency staff, and PRN Licensed Nurses, RNs, LPNs, and Medication Aides on the following topics: " Checking medications for expiration date prior to administering the medication. " Labeling medications when opened with date open as indicated. " McNeill□s Pharmacy recommended storage for selected items. This information has been integrated into the standard orientation training and will be reviewed by the Quality Assurance process to verify that the change has been sustained. As 08.20.2021, any staff who does not receive scheduled in-service training will not be allowed to work until training has been completed. The facility will review this information in their clinical meeting and discuss any issues at least weekly for the next 3 months unless the Quality Assurance Committee feels this issue has been resolved sooner. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Director of Nursing or designee will	

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F 761	Continued From page 52 4. In the presence of Nurse #3, an observation was conducted on 7/20/21 at 2:30 PM of the 200/300 Hall Med Room. The observation revealed an opened vial of Lantus insulin filled by the pharmacy on 6/13/21 (not dated when opened) for Resident #101 was stored in the refrigerator. Upon inquiry, Nurse #3 reported she did not know when the vial was opened. She stated the insulin vial needed to be discarded. A review of the manufacturer's storage instructions indicated once punctured (in use), a vial of Lantus insulin may be refrigerated or stored at room temperature; use within 28 days. An interview was conducted on 7/21/21 at 10:10 AM with the facility's Director of Nursing (DON). The findings of the Medication Storage task were discussed during the interview. When asked, the DON stated she would expect staff to watch for expired insulin and remove the insulin from the med room when it was expired.	F 761	monitor compliance utilizing the F761 Quality Assurance Tool weekly x 4 weeks then monthly x 3 months. The DON or designee will monitor for compliance with labeling medications with a date when opened and ensuring the cart and the medication room is free of expired medications. Reports will be presented to the weekly Quality Assurance committee by the DON to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance (QA) Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Coordinator, Therapy Manager, Unit Support Nurses, Health Information Manager, and the Dietary Manager.	
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.	F 812		8/20/21

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F 812	Continued From page 53 (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to maintain sanitary conditions in the kitchen by not labeling and dating resealed food items; by failing to store food items off the floor; by failing to ensure the kitchen was clean and free from debris; and by failing to ensure the meal tray service beverage refrigerator, food preparation and dishwashing sinks were maintained in good working condition. These practices had the potential to affect all residents. Findings included: 1a. On 7/19/21 at 9:50 a.m., multiple cases of dry food items and cases of food service supplies were observed on the floor in the dry storage room of the kitchen. Also, there were 3-resealed plastic bags of noodles and 1-large bag of brown rice stored on the storage racks but were not dated. During an interview on 7/19/21 at 9:51 a.m., the Assistant Dietary Manager (Assistant DM) revealed the items observed on the floor in the dry storage room were delivered three days prior to this date. 1b. On 7/19/21 at 10:19 a.m., during an observation of the walk-in freezer, there were 2-resealed plastic bags of unidentifiable breaded	F 812	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F812 1. For dietary services, a corrective action was obtained on 07.19.2021, 07.29.21, 08.09.2021, 08.11.2021. During initial walk through of the kitchen, it was noted dietary services had failed to store items off the floor, remove empty cardboard boxes, date 3 re-sealed bags of pasta noodles and 1 bag of brown rice, properly store a pan of cooked chicken tenders, and label or date resealed bags of unidentifiable breaded items. The Dietary Service Director properly stored items off the dry storage floor and discarded the cardboard boxes, 3 re-sealed bags of pasta noodles, 1 bag of brown rice, and pan of chicken tenders.	

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	345284	A. BUILDING _____ B. WING _____	C 07/23/2021

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F 812	Continued From page 54 items that were not dated or labeled and 1-6 inch deep pan of cooked chicken tenders covered with foil which was torn, exposing the chicken. 2a. During an observation of the kitchen on 7/19/21 at 9:40 a.m., the faucets of 2 of the 2 food preparation sinks had a persistent water drip when in the off position. Also observed was water leaking from the cold-water switch of the faucet at the sink located next to the dishwashing machine. During an interview on 7/21/21 at 12:25 p.m., the Dietary Manager (DM) stated he submitted a work order request to the facility's maintenance department approximately 2-3 weeks prior concerning the continuous drip/drizzle of the faucets of the 2-food preparation sinks and the leak from the cold-water handle at the sink next to the dishwashing machine. During an interview on 7/21/21 at 2:34 p.m., the Maintenance Director stated the leak in the sink at the dishwashing machine was repaired on 8/6/20 and the plumber was scheduled to return on 7/22/21 to repair this leak for the second time, the 2-faucets in the food preparation sinks, and 2 other leaks in the kitchen on 7/22/21. 2b. On 7/19/21 at 9:45 a.m., a large hole (approximately 6-inches wide and 5-inches in height) was observed in one of the walls in the kitchen. The hole was located directly above the floorboard next to the door which opened into the main dining room. During an interview on 7/21/21 at 12:25 p.m., the Dietary Manager (DM) revealed that approximately one month ago, he submitted a	F 812	During observation of kitchen, it was noted 2 of 2 faucets had a persistent water drip even in off position and water leaked from the cold water switch located next to the dish machine. Also, noted was a hole in the wall by the door leading into the dining room. A contracted plumber repaired faucets and cold water switch on 07.29.2021 and the Maintenance Director repaired the hole by the dining room door on 08.11.2021. During observation of tray line and use of beverage cooler, 3 sampled milks were tempted to be above 41 degrees despite the beverage cooler stating it was 38 degrees. All milks were removed from beverage cooler and instead collected from walk-in cooler for tray line until gaskets on beverage cooler were replaced. Gaskets replaced on 08.09.21. New refrigerator ordered 8.16.21. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents have the potential to be affected by the alleged deficient practice. On 7/19/2021, the Dietary Service Director completed a kitchen walk through to ensure all food items were labeled, dated, and stored properly. On 08.17.2021 the Dietary Service Director and Maintenance completed a kitchen walk through to ensure faucets, cold water switch, hole, and beverage gaskets had been repaired.	

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F 812	Continued From page 55 work order request to the facility's maintenance department for the needed repair of the large hole in the wall in the kitchen. During an interview on 7/21/21 at 2:34 p.m., the Maintenance Director stated he was informed about the hole in the wall in the kitchen approximately two weeks prior. He revealed he had the materials to repair the wall and the task had been added to his "to do" list. 2c. During an observation of the meal tray line service in the kitchen on 7/21/21 at 12:15 p.m., the inside thermometer reading of the beverage refrigerator was 38 degrees Fahrenheit but the temperatures of 3 of the 3 sampled 8-ounce cartons of milks tested were above the minimum requirement of 41 degrees Fahrenheit or below. The temperatures of the 3-sampled milks were 45.7 degrees Fahrenheit, 45.5 degrees Fahrenheit and 45.2 degrees Fahrenheit, respectfully. Dietary staff were instructed by the DM to remove the remaining milks from the refrigerator and to collect milk from the walk-in cooler as needed during the meal tray line service. Throughout this meal service tray line observation, there were no milks served from this beverage refrigerator. On 7/21/21 at 12:25 p.m., the DM revealed he submitted a work order request to the facility's maintenance department approximately 2-3 weeks prior due to the gasket of the refrigerator would not seal when closed. During an interview on 7/21/21 at 2:34 p.m., the Maintenance Director revealed that on 6/24/21 the refrigerator repairman informed him all 5-door gaskets of the beverage cooler needed to be	F 812	3. Systemic changes In-service education was provided to all full time, part time, and as needed staff. Topics included: " Storage and dating policies and regulations. " Inspections on shifts to observe all food to ensure they are labeled, dated, and stored properly. " Submitting work orders and maintenance follow-up. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff and will be reviewed by the Quality Assurance process to verify that the change has been sustained. 4. Quality Assurance monitoring procedure. The Dietary Service Director or designee will monitor procedures for proper food procurement, store/prepare/serve, and sanitation x 2 weeks then monthly x 3 months using the Dietary Quality Assurance Audit which will include inspections on both AM and PM shifts to observe that all food is labeled, dated, stored properly and that equipment is in proper working condition. Reports will be presented to the weekly Quality Assurance committee by the Administrator to ensure corrective action initiated as appropriate. Compliance will be monitored	

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F 812	Continued From page 56 replaced and returned approximately one week ago to remeasure the cooler for the gasket. At that time, the repairman told the dietary staff that until repaired, due to the temperature of the cooler, it could only be used for water and juices; they should not put dairy products in the cooler until it was repaired. The Maintenance Director stated he also informed the DM of the repairman's recommendation but was unable to recall the day. 3. During the tour of the kitchen on 7/19/21 at 9:36a.m., there was an observation of empty cardboard boxes stacked haphazardly on the floor. Throughout the kitchen, the floor was observed to be dirty with a brown film covering. During an interview on 7/19/21 at 9:36 a.m., the Assistant DM revealed dietary staff mopped the kitchen's floor at the end of the shift, the night before.	F 812	and ongoing auditing program reviewed at the weekly Quality Assurance (QA) Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Coordinator, Therapy, Health Information Manager, and the Dietary Manager	
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility	F 842		8/20/21

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F 842	Continued From page 57	F 842		

must maintain medical records on each resident that are-
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

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F 842	Continued From page 58 §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interviews, the facility failed to reflect the correct type of hemodialysis vascular access site in the medical record for 1 of 1 resident reviewed for dialysis (Resident #46). The findings included: Resident #46 was admitted to the facility on 9/3/20 with a diagnosis of end stage renal disease with dependence on dialysis. A quarterly Minimum Data Set (MDS) assessment dated 4/21/21 revealed Resident #46 was cognitively intact. Resident #46 received dialysis during the look back period. The care plan (date not recorded) revealed a focus area of dialysis with intervention to include monitor shunt site for thrill and bruit and do not draw blood or take blood pressure in arm with shunt. The July 2021 physician's orders revealed an active order to check permacath for bleeding and	F 842	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F842 1. Corrective action for resident(s) affected by the alleged deficient practice: The order for the Resident #46 was revised to reflect the correct dialysis vascular access site by the Director of Nurses on 07.26.2021. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice.	

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F 842	Continued From page 59 signs and symptoms of infection and document adverse findings in nurse's notes every shift. A second active order for permacath dressing to remain in place at all times was also noted and a third active order for bedbath only due to permacath in right upper chest until further notice. A review of the July 2021 Medication Administration Record revealed documentation to indicate Resident #46 had a permacath present. On 7/19/21 at 11:11 AM, an interview was conducted with Resident #46. He stated the staff told him he couldn't receive showers due to his dialysis site. Resident #46 added he no longer had a permacath and now had a shunt for dialysis. On 7/21/21 at 2:09 PM, an interview was conducted with Nurse #1 who stated when Resident #46 returned from dialysis, she gave him his medications, asked him if he needed anything, checked his dialysis site for bleeding and listened for bruit and thrill. She stated she knew he no longer had a permacath but didn't know why it wasn't changed in the physician's orders. On 7/22/21 at 4:30 PM, an interview was conducted with the Director of Nursing. She stated the medical record should have been updated by the nurse when Resident #46 had the permacath removed.	F 842	On 08.09.2021 the Director of Nurses/Evening Nurse Supervisor completed a 100% audit of all residents dialysis vascular access site to ensure that the accurate site was documented in the resident record. 3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: On 07.23.2021, the DON, Treatment Nurse, Administrator, and the Quality Assurance Clinical Nurse Consultant reviewed the policy on nursing documentation. There were no changes required for the policy. On 07.25.2021, the Director of Nurses/Staff Development Coordinator began education of all full time, part time and as needed nurses and agency nurses on ensuring that all resident medical records are complete in accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are complete and accurately documented including the correct dialysis vascular access site. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. Any staff who does not receive scheduled in-service training will not be allowed to work until training has been completed by 08.20.2021.	

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F 842	Continued From page 60	F 842	The facility will review this information in their clinical meeting and discuss any issues at least weekly for the next 3 months unless the Quality Assurance Committee feels this issue has been resolved sooner. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The DON or designee will monitor compliance utilizing the F842 Quality Assurance Tool weekly x 4 weeks then monthly x 3 months. The DON will monitor compliance to ensure that all dialysis residents have the correct dialysis vascular access site documented in the resident record. Reports will be presented to the weekly Quality Assurance committee by the DON to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance (QA) Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Coordinator, Unit Support Nurses, Therapy Manager, Health Information Manager, and the Dietary Manager.	
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control	F 880		8/20/21

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F 880	Continued From page 61	F 880		

The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.

§483.80(a) Infection prevention and control program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism

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F 880	Continued From page 62 involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility failed to post the appropriate signage and implement Enhanced Droplet Precautions as recommended by the Center for Disease Control and Prevention (CDC) and as directed by the facility's policy for 8 of 9 newly admitted residents who were either unvaccinated against COVID-19 or whose vaccination status was unknown (Residents #415, #419, #413, #417, #114, #420, #422 and #421). These failures occurred during a global pandemic. The findings included:	F 880	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F 880	

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F 880	Continued From page 63 Review of CDC guidance titled, "Infection Control for Nursing Homes" with a Summary of Recent Changes (updates dated 3/29/21) for managing new admissions and readmissions read in part: "In general, all other new admissions and readmissions should be placed in a 14 day quarantine even if they have a negative test upon admission. Exceptions include residents within 3 months of a SARS-CoV-2 (COVID-19) infection and fully vaccinated residents." Review of a facility policy titled, "COVID19 Program V 25" (Effective July 2021) addressed Resident Care. This policy read in part: "1. Admissions d. New admission and readmission placement i. Unvaccinated new admissions and readmission are to be enhanced precautions for at least 14 days unless discharged to home or another location prior to the completion of the 14 days. See exception below for past positive patients. ii. Readmissions should be placed on enhanced precautions in a private room when available. iii. New admission/readmissions that have tested positive for COVID-19 in the past 90 days and do not have active signs or symptoms of COVID-19 do not require 14 days of enhanced precautions. However, they must have completed the requirements for discontinuation of isolation, or they must be admitted to a COVID-19 unit. iv. Fully vaccinated new admission or readmissions are not required to quarantine and may be placed in semi-private rooms. v. Vaccination status should be	F 880	1. How corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident #415, #419, #413, #417, #114, #420, #422, & #421 were not affected by the deficient practice. On 07.20.2021, the Assistant Director of Nurses (ADON) ensured that each resident had an Enhanced Droplet Isolation Sign on their door. No residents were identified as affected. On 07.20.2021, the Director of Nurses audited to assure appropriate isolation signage for enhanced droplet precautions had been placed on the doors of rooms #415, #419, #413, #417, #114, #420, #422, & #421 and educated the staff working on the Enhanced Droplet Isolation Hall that day ensuring that Enhanced Droplet Precaution signs are maintained on doors for the required residents on precautions. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice: On 07.23.2021, the Staff Development Coordinator began an audit of the Enhanced Droplet Isolation Hall to observe the signage on the resident doors and to observe staff compliance with appropriate hand hygiene practice and Personal Protective Equipment (PPE) when entering and exiting resident rooms and during resident care.	

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F 880	Continued From page 64 documented in PCC (the electronic medication record) on admission." 1-a) Resident #415 was admitted to the facility on 7/9/21 and resided on the 100 Hall. The resident's cumulative diagnoses included Parkinson's dementia. The resident's medical record revealed there was no documentation or evidence of his COVID-19 vaccination status upon admission to the facility. An observation conducted on 7/19/21 at 9:55 AM of the 100 Hall revealed only one resident's room (not Resident #415's) had signage to indicate the resident was on Enhanced Droplet Precautions. There was no signage placed on or near Resident #415's doorway to indicate this resident was on Enhanced Droplet Precautions. An interview was conducted on 7/19/21 at 10:00 AM with Medication Aide #1. Med Aide #1 was assigned to work on the 100 Hall. Upon inquiry, the Med Aide confirmed only one resident on the hallway (with the signage placed by her door) was on Enhanced Droplet Precautions. An observation was conducted on 7/19/21 at 1:29 PM as the facility's Speech-Language Pathologist (SLP) carried a meal tray into Resident #415's room. There was no signage placed on or near the resident's doorway to indicate he was on Enhanced Droplet Precautions at that time. The SLP was wearing a mask but was not wearing eye protection, a gown, or gloves upon entering the room. A review of Resident #415's medical record included an SLP note dated 7/19/21 which reported the resident was treated for swallowing dysfunction and/or oral function. The note	F 880	The Director of Nurses (DON), will also ensure that every resident will have their vaccination status entered within 24 hours of admission to identify the residents isolation status. 3. Address what measures will be put in place or systematic changes made to ensure that the deficient practice will not reoccur: Education: On 07.26.2021, the DON, Administrator, and the Quality Assurance Clinical Nurse Consultant reviewed the policy on the COVID-19 Program. There were no changes required for the policy. On 07.25.2021, the Director of Nurses (DON), and the Assistant Director of Nurses (ADON) who are all Infection Preventionist who have completed a course in Infection Control via NC SPICE initiated education for all full time, part time, PRN staff, and agency staff on the Center for Disease Control□s (CDC) recommended practice on donning/doffing of PPE, hand hygiene policy, and re-education on ensuring isolation signage is in place at all times on enhanced droplet precaution room doors. On 07.26.2021 the Administrator, DON and ADON-Infection Control Preventionist implemented Infection Control rounds to ensure the presence of appropriate enhanced droplet isolation signage on all doors for those residents on enhanced droplet precautions.	

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F 880	Continued From page 65 indicated Resident #415 was fed in his room at bedside on 7/19/21 with total feeding assistance provided. The estimated time for treatment was 40 minutes. An observation made on 7/20/21 at 7:55 AM again revealed there was no signage on or near Resident #415's doorway to indicate the resident was on Enhanced Droplet Precautions. An interview was conducted on 7/20/21 at 3:20 PM with the facility's SLP. During the interview, the SLP was asked if she had been aware Resident #415 was on Enhanced Droplet Precautions when she fed him his lunch meal on 7/19/21. The SLP reported she had not been aware of this. However, she stated she did see an Enhanced Droplet Precautions sign was posted on this date (7/20/21) to alert staff to the precautions. 1-b) Resident #419 was admitted to the facility on 7/9/21 and resided on the 100 Hall. The resident's cumulative diagnoses included a history of diabetic ketoacidosis (a serious complication of diabetes that occurs when ketones or acids build up in the blood). The resident's medical record revealed there was no documentation or evidence of his COVID-19 vaccination status upon admission to the facility. A physician order was received on 7/9/21 for the resident to be placed on Enhanced Droplet Precautions for a period of 14 days. An observation conducted on 7/19/21 at 9:55 AM of the 100 Hall revealed only one resident ' s room (not Resident #419's) had signage to indicate the resident was on Enhanced Droplet	F 880	This information has been integrated into the standard orientation training and will be reviewed by the Quality Assurance process to verify that the change has been sustained. As of 08.20.2021, any staff who does not receive scheduled in-service training will not be allowed to work until training has been completed. The facility will review this information in their clinical meeting and discuss any issues at least weekly for the next 3 months unless the Quality Assurance Committee feels this issue has been resolved sooner. Root Cause Analysis: A Root Cause Analysis was initiated on 08.13.2021 to discuss the root cause analysis of this event where the Isolation Signage for residents on Enhanced Droplet Precautions were not it place. The team members participating in the Root Cause Analysis included the following staff members: Administrator, DON, ADON, Staff Development Nurse (SDC), Licensed Practical Nurse, Certified Nursing Assistant, Environmental Service Director, and the Medical Director. The team identified that lack of knowledge of the staff assisting in the room moves and distraction from various things going on in the facility contributed to the deficient practice. A follow up meeting will be held weekly to discuss ongoing solutions to address the root cause for a period of at least 6 months unless the Quality	

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Precautions. There was no signage placed on or near Resident #419's doorway to indicate this resident was on Enhanced Droplet Precautions.

An interview was conducted on 7/19/21 at 10:00 AM with Medication Aide #1. Med Aide #1 was assigned to work on the 100 Hall. Upon inquiry, the Med Aide confirmed only one resident on the hallway (with the signage placed by her door) was on Enhanced Droplet Precautions.

An observation made on 7/20/21 at 7:55 AM again revealed there was no signage on or near Resident #419's doorway to indicate the resident was on Enhanced Droplet Precautions.

1-c) Resident #413 was admitted to the facility on 7/16/21 and resided on the 100 Hall. The resident's cumulative diagnoses included fibromyalgia.

The resident's medical record revealed there was no documentation or evidence of her COVID-19 vaccination status upon admission to the facility. A physician order was received on 7/16/21 for the resident to be placed on Enhanced Droplet Precautions for a period of 14 days.

An observation conducted on 7/19/21 at 9:55 AM of the 100 Hall revealed only one resident's room (not Resident #413's) had signage to indicate the resident was on Enhanced Droplet Precautions. There was no signage placed on or near Resident #413's doorway to indicate this resident was on Enhanced Droplet Precautions.

An interview was conducted on 7/19/21 at 10:00 AM with Medication Aide #1. Med Aide #1 was assigned to work on the 100 Hall. Upon inquiry,

Assurance (QA) Committee deems it can end before the 6 months. The follow up root cause analysis meeting will be attended by the Administrator, DON, ADON, Minimum Data Set Nurse (MDS), Health Information Manager, Dietary Manager, Environmental Service Director, and the Business Office Manager, all of who are members of the facility Quality Assurance and Performance Committee. This Root Cause Analysis will be a part of our ongoing Performance Improvement Process.

4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements:

The Director of Nursing or designee will monitor compliance utilizing the F880 Quality Assurance Tool weekly x 4 weeks then monthly x 3 months. The DON or designee will monitor for compliance with isolation signage being in place for any residents on Enhanced Droplet Precautions. Monitoring will be conducted across all three shifts and include weekends. Reports will be presented to the weekly Quality Assurance (QA) committee by the DON to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Nurse,

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F 880	Continued From page 67 the Med Aide confirmed only one resident on the hallway (with the signage placed by her door) was on Enhanced Droplet Precautions. An observation of Resident #413's doorway made on 7/19/21 at 3:44 PM revealed there was no signage to indicate the resident was on Enhanced Droplet Precautions. An observation of Resident #413 was conducted on 7/19/21 at 3:44 PM in her room as she laid sleeping in her bed with a family member at bedside. An interview was also conducted with the family member in Resident #413's room at that time as part of the facility's recertification process. The family member was observed to be wearing a surgical face mask only with no other PPE worn. An observation made on 7/20/21 at 7:55 AM again revealed there was no signage on or near Resident #413's doorway to indicate the resident was on Enhanced Droplet Precautions. 1-d) Resident #417 was admitted to the facility on 7/12/21 and resided on the 100 Hall. The resident's cumulative diagnoses included a saddle embolus of the pulmonary artery (a large blood clot where the main pulmonary artery branches off into each lung). The resident's medical record revealed there was no documentation or evidence of her COVID-19 vaccination status upon admission to the facility. An observation conducted on 7/19/21 at 9:55 AM of the 100 Hall revealed only one resident's room (not Resident #417's) had signage to indicate the resident was on Enhanced Droplet Precautions. There was no signage placed on or near Resident #417's doorway to indicate this resident	F 880	Therapy Manager, Unit Support Nurses, Health Information Manager, and the Dietary Manager. Directed Plan of Correction Compliance Date: 08.20.2021 Compliance Date: 08.20.2021	

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was on Enhanced Droplet Precautions.

An interview was conducted on 7/19/21 at 10:00 AM with Medication Aide #1. Med Aide #1 was assigned to work on the 100 Hall. Upon inquiry, the Med Aide confirmed only one resident on the hallway (with the signage placed by her door) was on Enhanced Droplet Precautions.

An observation of Resident #417's doorway made on 7/19/21 at 2:45 PM revealed there was no signage to indicate the resident was on Enhanced Droplet Precautions. An observation and interview were conducted on 7/19/21 at 2:45 PM with Resident #417 in her room as part of the facility's recertification process.

An observation made on 7/20/21 at 7:55 AM again revealed there was no signage on or near Resident #417's doorway to indicate the resident was on Enhanced Droplet Precautions.

1-e) Resident #114 was admitted to the facility on 7/18/21 and resided on the 100 Hall. The resident's cumulative diagnoses included a recent history of a right closed ankle fracture.

The resident's medical record revealed there was no documentation or evidence of her COVID-19 vaccination status upon admission to the facility. A physician order was received on 7/18/21 for the resident to be placed on Enhanced Droplet Precautions for a period of 14 days.

An observation conducted on 7/19/21 at 9:55 AM of the 100 Hall revealed only one resident's room (not Resident #114's) had signage to indicate the resident was on Enhanced Droplet Precautions. There was no signage placed on or near

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Resident #114's doorway to indicate this resident was on Enhanced Droplet Precautions.

An interview was conducted on 7/19/21 at 10:00 AM with Medication Aide #1. Med Aide #1 was assigned to work on the 100 Hall. Upon inquiry, the Med Aide confirmed only one resident on the hallway (with the signage placed by her door) was on Enhanced Droplet Precautions.

An observation made on 7/20/21 at 7:55 AM again revealed there was no signage on or near Resident #114's doorway to indicate the resident was on Enhanced Droplet Precautions.

1-f) Resident #420 was admitted to the facility on 7/15/21 and resided on the 100 Hall. The resident's cumulative diagnoses included a history of diabetic ketoacidosis (a serious complication of diabetes that occurs when ketones or acids build up in the blood).

The resident ' s medical record revealed there was no documentation or evidence of her COVID-19 vaccination status upon admission to the facility.

An observation conducted on 7/19/21 at 9:55 AM of the 100 Hall revealed only one resident's room (not Resident #420's) had signage to indicate the resident was on Enhanced Droplet Precautions. There was no signage placed on or near Resident #420's doorway to indicate this resident was on Enhanced Droplet Precautions.

An interview was conducted on 7/19/21 at 10:00 AM with Medication Aide #1. Med Aide #1 was assigned to work on the 100 Hall. Upon inquiry, the Med Aide confirmed only one resident on the

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hallway (with the signage placed by her door) was on Enhanced Droplet Precautions.

An observation made on 7/20/21 at 7:55 AM again revealed there was no signage on or near Resident #420's doorway to indicate the resident was on Enhanced Droplet Precautions.

1-g) Resident #422 was admitted to the facility on 7/12/21 and resided on the 100 Hall. The resident's cumulative diagnoses included chronic obstructive pulmonary disease.

The resident's medical record revealed there was no documentation or evidence of her COVID-19 vaccination status upon admission to the facility. A physician order was received on 7/12/21 for the resident to be placed on Enhanced Droplet Precautions for a period of 14 days.

An observation conducted on 7/19/21 at 9:55 AM of the 100 Hall revealed only one resident's room (not Resident #422's) had signage to indicate the resident was on Enhanced Droplet Precautions. There was no signage placed on or near Resident #422's doorway to indicate this resident was on Enhanced Droplet Precautions.

An interview was conducted on 7/19/21 at 10:00 AM with Medication Aide #1. Med Aide #1 was assigned to work on the 100 Hall. Upon inquiry, the Med Aide confirmed only one resident on the hallway (with the signage placed by her door) was on Enhanced Droplet Precautions.

An observation made on 7/20/21 at 7:55 AM again revealed there was no signage on or near Resident #422's doorway to indicate the resident was on Enhanced Droplet Precautions.

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1-h) Resident #421 was admitted to the facility on 7/10/21 and resided on the 100 Hall. The resident's cumulative diagnoses included a history of a subdural hematoma (aa type of bleed that hat occurs within the skull of head but outside the actual brain tissue).

The resident ' s medical record revealed there was no documentation or evidence of her COVID-19 vaccination status upon admission to the facility. A physician order was received on 7/9/21 for the resident to be placed on Enhanced Droplet Precautions for a period of 14 days.

An observation conducted on 7/19/21 at 9:55 AM of the 100 Hall revealed only one resident's room (not Resident #421's) had signage to indicate the resident was on Enhanced Droplet Precautions. There was no signage placed on or near Resident #421's doorway to indicate this resident was on Enhanced Droplet Precautions.

An interview was conducted on 7/19/21 at 10:00 AM with Medication Aide #1. Med Aide #1 was assigned to work on the 100 Hall. Upon inquiry, the Med Aide confirmed only one resident on the hallway (with the signage placed by her door) was on Enhanced Droplet Precautions.

An observation made on 7/20/21 at 7:55 AM again revealed there was no signage on or near Resident #421's doorway to indicate the resident was on Enhanced Droplet Precautions.

An interview was conducted on 7/20/21 at 12:57 PM with the facility's Assistant Director of Nursing (ADON). The ADON was identified as the nurse responsible for Infection Control. During the

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interview, the nurse was asked which residents were intended to be on Enhanced Droplet Precautions. The nurse reported nine (9) residents on the 100 Hall were on Enhanced Droplet Precautions. She also reported there were no active COVID-19 cases in the facility at this time. The ADON stated upon admission to the facility, an order was put into the resident's electronic medical record (EMR) and a sign posted at the resident's doorway to initiate Enhanced Droplet Precautions for 14 days. Once the resident's vaccination card was received to document he/she was fully vaccinated, the order for Enhanced Droplet Precautions would be discontinued. The nurse reported Enhanced Droplet Precautions required the following Personal Protective Equipment (PPE) to be worn upon entering the resident's room: N95 mask, face shield (eye protection), gown and gloves. During the interview, concern was expressed regarding only one resident's room having an Enhanced Droplet Precautions sign posted on 7/19/21 and the morning of 7/20/21. Staff member(s), visitor(s), and surveyor(s) had been unaware of the need to don the necessary PPE upon entering 8 of the 9 residents' rooms who were intended to be on Enhanced Droplet Precautions.

Accompanied by the ADON, an observation was made of the 100 Hall on 7/20/21 at 1:00 PM. At that time, an Enhanced Droplet Precautions sign was posted at the doorway of 7 residents' rooms (including Residents #413, #417, #114, #420, #422 and #421). However, no signage was placed on or near Resident #415's or Resident #419's doorway to indicate either of these residents were on Enhanced Droplet Precautions. The nurse reported an Enhanced Droplet

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Precautions sign would need to be posted for these residents.

On 7/20/21 at 1:10 PM, the ADON provided a list of residents who were currently intended to be on Enhanced Droplet Precautions. This list included a total of nine (9) residents on the 100 Hall and included Residents #415, #419, #413, #417, #114, #420, #422 and #421.

A follow-up interview was conducted with the ADON on 7/21/21 at 2:02 PM. During this interview, the nurse reported residents on the 100 Hall had been moved around with room changes the week prior to the survey. She stated the signs for Enhanced Droplet Precautions had been put in the PPE drawers instead of being posted and visible upon entering the room. However, she stated Resident #413 was recently admitted on 7/16/21 and the signage for her Enhanced Droplet Precautions was missed. The ADON reported the nurse that was on the hall when Resident #413 was admitted should have posted the signage for her Enhanced Droplet Precautions.

An interview was conducted on 7/22/21 at 9:10 AM with the facility's Environmental Services Manager. During the interview, the Manager reported she noticed there had been a lot of room changes on the 100 Hall and most of the Enhanced Droplet Precautions signs had been taken down. She stated, "I wondered if we were done doing that." When asked, she reported her staff were going in and out of the rooms at that point since they were not aware the Enhanced Droplet Precautions were in place. The Manager confirmed only one Enhanced Droplet Precautions sign and two PPE carts were on the

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hall as of 7/19/21 (the date of the survey entry). The Manager reported more signs have since been posted and that she herself placed three or four additional PPE carts on the 100 Hall during the mid to late morning of 7/20/21.

An interview was conducted on 7/22/21 at 3:19 PM with the facility's Director of Nursing (DON) with regards to the failure of the facility to post signage and observe Enhanced Droplet Precautions for 8 of the 9 residents on the 100 Hall. The DON reported she had noticed on 7/20/21 there were fewer signs for Enhanced Droplet Precautions than she had previously seen. When asked, the DON stated her expectation would be for the staff to leave the signage in place until the leadership team evaluated whether the resident could come off of the precautions in accordance with their facility policy.